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Background Paper 7

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University of British Columbia

March 1983

This is one in a series of background papers prepared for the Task Force on Skill Development Leave. The opinions expressed are those of the author(s) and do not necessarily reflect the views of the Task Force or the Department of Employment and Immigration.

Control No. WH1-068E

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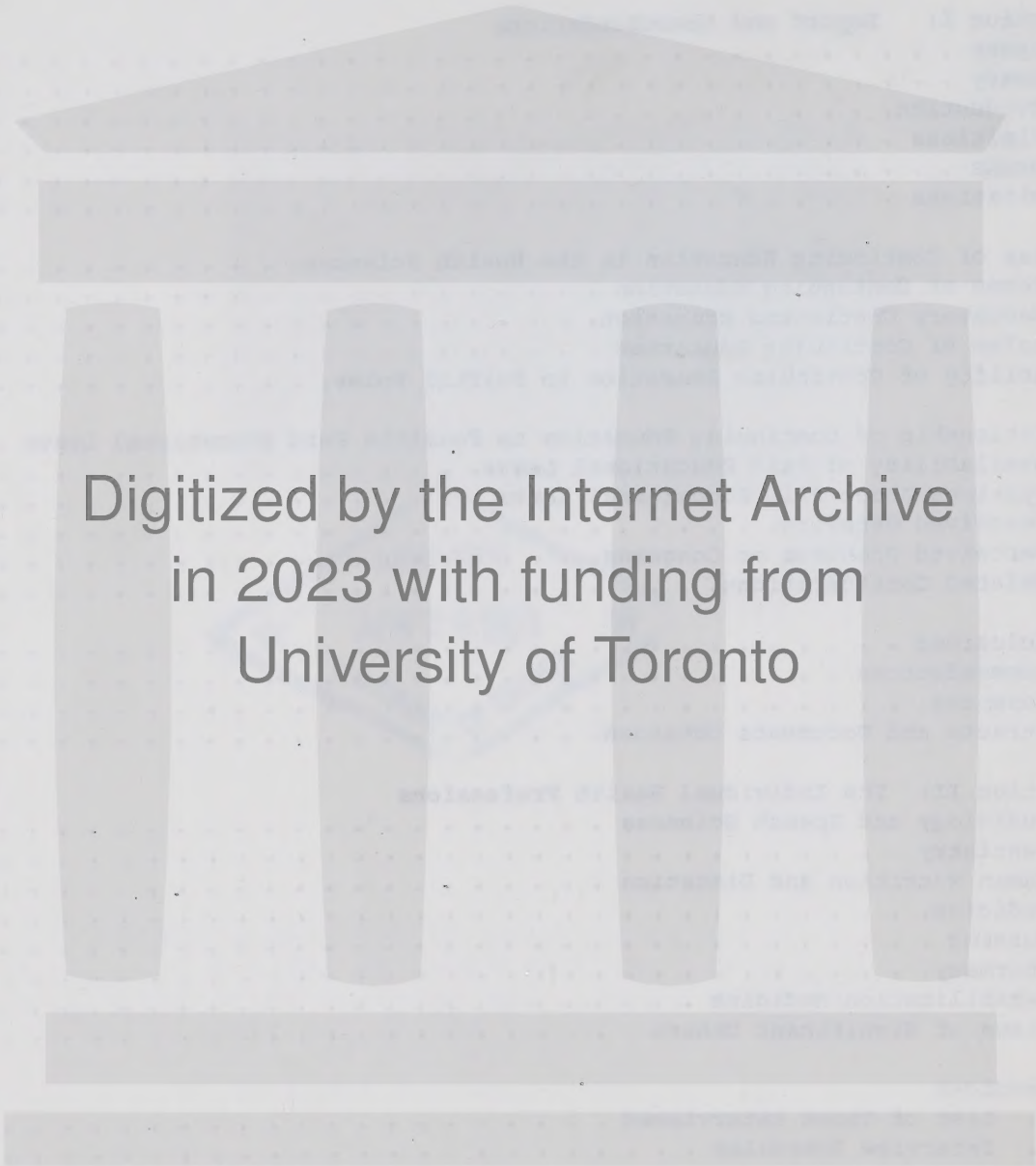

SECTION I

REPORT AND RECOMMENDATIONS

PURPOSE

The purpose of this report is to describe the role of continuing education in the health sciences and the relationship of continuing education in the several health professions to possible paid educational leave for members of those professions.

SUMMARY

1. Continuing education is offered in a variety of forms for health professionals in British Columbia, the most common of which are short courses, lectures or lecture series. Most are offered in major centres although "community" courses are offered by some professions and distance education delivery systems such as satellite transmission of televised programs and correspondence courses are employed.

2. Continuing education is a condition of licensure only in Dentistry (for Dentists and Dental Hygienists). It is required for membership in one voluntary professional association and is being considered by two others.

3. The major roles of continuing education are perceived to be: maintaining basic competence, acquiring new knowledge and skills, facilitating role changes, and professional advancement.

4. There is no clear agreement about whether continuing education as it currently exists is adequately fulfilling its major roles. Some respondents felt they are being fulfilled. Others expressed uncertainty because no means are in place to access the relationship between continuing education, professional competence, and the quality of care; and therefore feel no answer to the question is possible. The majority indicated the major roles are not being fulfilled. Principal reasons given included: access factors (e.g. geographic remoteness, lack of replacement personnel), cost factors (e.g. income loss, lack of funds for replacement personnel, travel costs) and programming factors (e.g. availability of relevant topics and program types at convenient places and times).

5. Educational leave is available to health professionals in a variety of forms. Access to leave is not uniformly available even when provided for in written agreements, and leave, when available, is not always with pay. Professions and specialty groups with small numbers and those in remote communities appear to have least access to paid leave.

6. Most respondents felt a universal system of paid educational leave for health professionals is desirable because of improvements in health care that are expected to result. Many questioned whether it is advisable, principally because they predict substantial costs.

7. Perceived benefits of a system of paid leave include: increased participation, improved access to programs, stimulated professional growth

and development, improved educational programs, the development of new programs and delivery systems, and specific benefits to employers and employees such as increased job satisfaction resulting in reduced staff turnover and other advantages.

8. The principal concern expressed about a paid leave system is the apparent tremendous costs. A number of types of costs are identified: costs to professional associations, employers, educational providers and government. Other concerns include a lack of replacement personnel and of appropriate educational programs, facilities, personnel and evaluation systems.

9. It is agreed health professionals should be accountable for a portion of the costs of continuing professional education.

10. It is agreed any system of paid educational leave should be universally available to all health professionals. Concern is expressed for special groups: e.g. the unemployed and the disabled.

11. Specific suggestions are made about ways in which such a system could be implemented. The B.C. Medical Education Fund is cited as a possible system for professionals remunerated on a fee-for-service basis. Pharmacare programs could be used to obtain funds for continuing education for pharmacists by withholding a few cents for each prescription processed.

12. It is concluded continuing education for health professionals has important and specific roles that are not being adequately fulfilled by existing programs, and that a system of paid educational leave could contribute signifcantly to enabling those roles to be fulfilled.

13. It is recommended the feasibility of implementing a universal system of paid educational leave for health professionals be studied in greater depth with opportunity for input from all interested parties and with due regard for needed research and evaluation.

14. It is recommended further that in the short term, existing provisions for leave be scrutinized, clarified as required and enforced as appropriate to ensure they are accessible to all to whom they apply.

INTRODUCTION

New knowledge and skills are being identified and introduced at an accelerating rate in all areas of the health sciences. Moreover, knowledge and skills not reinforced by consistent use tend to deteriorate. Some estimate 65 percent of the knowledge and skills acquired by health professionals in undergraduate training are lost or become obsolete in the first five years of practice. As a consequence, continuing education is a vital necessity for all health professionals if an appropriate level of professional competence and an acceptable quality of health care is to be maintained.

Continuing education is available in a variety of forms in British Columbia and participation in continuing education activities is strongly endorsed and actively encouraged by professional associations and licencing bodies. In spite of this, the level of participation by B.C. health professionals is lower than is felt to be desirable. Many factors influence participation. Some of them relate to the unique characteristics of the individual health professional learners: attitudes toward their profession, motivation to engage in continued learning, willingness to accept change, etc. Others relate to personal and professional roles and the requirements and conflicts created by those roles: demanding work schedules, shift work, family responsibilities, community service obligations, etc. Still others relate to specific barriers that limit or even preclude participation by some health professionals who wish to engage in continued learning: inability to obtain leave to participate; the various costs of participation (tuition fees, travel, accommodation and possible loss of earnings); geographic remoteness; lack of replacement personnel; lack of relevant and timely programs; among others.

One of the basic findings of the Report of the Commission of Inquiry on Educational Leave and Productivity was: "Professionals and other skilled people should be expected to keep their skills up to date and should have the means to do so."[1] A universal system of paid educational leave is considered by some as an important possible means of accomplishing that goal because of its potential ability to diminish or remove several important barriers to participation. This report will examine the implications of a possible system of paid educational leave as perceived by informed members of the health sciences community.

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[1] Education and Working Canadians: Report of the Commission of Inquiry on Educational Leave and Productivity. R.J. Adams, Chairman. P.M. Draper and C. Ducharme, Members. Labour Canada, Ottawa. June 1979, p.222.

DEFINITIONS

1. Continuing Education in the Health Sciences.

"Systematic learning activities designed to enable health professionals to maintain and/or upgrade their competence to provide health care..."[1]

For the purpose of this submission, the term "continuing education":

a) Includes formal educational activities engaged in by health professionals following completion of their basic professional qualifications regardless of length and whether for credit or non-credit.

b) But does not include:

i) Informal learning activities (reading journal literature, consultation with colleagues, etc)

ii) Full time study in degree programs

iii) Post-graduate clinical programs leading to recognized, licensed specialty qualifications (e.g. Medical residency programs).

2. Paid Educational Leave.

a) "Educational leave" is interpreted in this submission to mean absence from the place of employment during normal hours of employment for the purpose of engaging in continuing education activities.

b) "Paid leave" is interpreted as meaning:

i) Continuation of all or part of salary during the period of the leave, and/or

ii) Payment of all or part of the expenses incurred as a result of participating in the educational activity: e.g. tuition fees, travel and accommodation costs, replacement salaries, office "overhead", etc.

It is recognized informal learning activities make up an important part of the spectrum of continuing education engaged in by most health professionals. However, because of the obvious problems of monitoring participation in such activities, they have not been considered as activities for which paid educational leave might be granted.

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[1] Manual of Continuing Education in the Health Sciences. Division of Continuing Education in the Health Sciences. University of British Columbia. Draft in progress: March 1983, p.2.

PROCESS

The following process was used in compiling this report:

1. Relevant reports, documents, contracts, agreements and related materials were identified, obtained and consulted.

2. Individuals who were likely to have an informed opinion on continuing education and paid educational leave were identified. These included directors of continuing education in the several health professions at the University of British Columbia, representatives of professional associations and licencing bodies, and other individuals prominent in the health care field who were likely to have an informed opinion on the matter. Names and addresses of those interviewed are listed in Appendix A.

3. Interview schedules were prepared and tested. Copies of the schedules used are presented in Appendix B.

4. Interviews were conducted and transcribed.

5. Results of the interviews were collated into separate summaries for each professional group. These summaries are presented in Section II of this report.

6. The summaries were combined into a comprehensive report presenting the major findings. Conclusions were drawn and recommendations made.

LIMITATIONS

This report has the following limitations:

1. Information was obtained only with respect to the following professions: Audiology, Dentistry, Human Nutrition and Dietetics, Medicine, Nursing, Occupational Therapy, Pharmacy, and Physiotherapy. Many other groups of health personnel can be expected to have informed opinions on this subject. Those opinions may differ from the findings of this report.

2. Only British Columbia representatives of the health professions named above were consulted. Representatives of those professions in other jurisdictions can be expected to have informed opinions that may differ from the findings of this report.

3. Those interviewed for this report were asked to provide only their perceptions and informed opinions. They were not asked and did not volunteer to make official statements on behalf of any organization, agency, institution or association with which they are presently associated or have been associated.

4. The report as written does not present information from those interviewed in exactly the form in which it was received. Responsibility for any errors it contains and for the conclusions and recommendations rests solely with the author.

ROLE OF CONTINUING EDUCATION IN THE HEALTH SCIENCES

FORMS OF CONTINUING EDUCATION

The following forms of continuing education were reported by those interviewed as being available to health professionals in British Columbia.

1. Formal Continuing Education.
   Activities planned by an educational agent and conducted under the direct or indirect supervision of the agent (or his delegate), who is in consistent communication with the learners.
   a) Short courses, conferences, institutes, workshops, seminars, (typically 1 to 5 days in length)
   b) Intensive short courses and post-basic training programs (full or part-time, typically 2 weeks to 1 year FTE)
   c) Sequential series of short courses leading to incremental qualifications. (Course A is pre-requisite for Course B. Courses A to E might be required for full qualification)
   d) Traineeships: full time individual or very small group study and clinical training (1 week to 6 months)
   e) Special lectures, hospital rounds (1 - 3 hours)
   f) Lecture series (1 - 3 hours over 3 to 16 weeks)
   g) Educational events associated with professional meetings or conferences
   h) In-service training
   i) Study clubs and journal clubs
   j) Televised programs transmitted via satellite
   k) Audio-conferences via telephone
   l) Guided independent study
   m) Correspondence courses: print materials
   n) Guided clinical study: simulations or in situ.

2. Informal Continuing Education.
   These activities may or may not be planned by an educational agent. Any supervision is indirect. The agent may not be in consistent communication with the learner. Self-report of participation by the learner would be required.
   a) Consultations with colleagues
   b) Reading journal literature and learned tests
   c) Videotape and audiotape lending or sales sytems
   d) Attending exhibits
   e) Individual study.

3. Other.
   The following activities were reported as eligible for continuing education credits by one group:
   a) Writing for publication
   b) Teaching.

MANDATORY CONTINUING EDUCATION

The question of mandatory (required) continuing education was examined on the presumption that where participation in continuing education is required for licensure or for membership in a professional body, the issue of paid educational leave would be of considerable importance.

The present situation with regard to mandatory continuing education for health professionals in British Columbia is as follows:

1. Continuing education is a condition of licensure only for Dentists and Dental Hygienists.

2. As part of the College of Pharmacists of British Columbia "Competency Assessment Project," all Pharmacists are required to take written tests at intervals. Specific continuing education programs are mandated for those Pharmacists who do not perform well on the tests.

3. Continuing education is mandatory for membership in the British Columbia Dietitians' and Nutritionists' Association. However, membership in the association is voluntary.

4. The Canadian College of Family Physicians has a mandatory continuing education requirement for membership. However, membership is voluntary. General Practitioners can practice in British Columbia without this membership.

5. Some British Columbia health professionals are licensed to practice in jurisdictions outside British Columbia which require continuing education as a condition of licensure. Similarly, some belong to specialty societies in other jurisdictions which require continuing education as a condition of membership. In both instances, participation is voluntary because these individuals can continue to practice in British Columbia without those licences and memberships.

6. Mandatory continuing education is being considered by the B.C. Society of Occupational Therapists and the B.C. Speech and Hearing Association as a condition of membership. Compulsory registration or licensure do not exist for Occupational Therapists, Speech Language Pathologists, or Audiologists at present. Membership in the professional bodies is voluntary.

7. Mandatory continuing education does not exist at the present time in the other professions and apparently is not being considered.

ROLES OF CONTINUING EDUCATION

The following perceived roles of continuing education in the health sciences were identified by those interviewed. They are listed in the order of frequency with which they were mentioned. All professions mentioned roles 1 to 4.

1. Maintaining basic competence.

2. Acquiring new knowledge and skills.

3. Facilitating role changes.

4. Professional advancement.

5. Socialization: informal interchange among participants resulting in the exchange of information, developing and strengthening professional relationships, and strengthening professional support systems.

6. Re-entry to professions for those not in practice.

7. Continuing development and reinforcement of professional values. (Helps participants view their professions as dynamic careers and not merely "jobs". Establishes and reinforces commitments to lifelong learning).

8. Contributing to the field of knowledge about how adults learn through research and publication related to continuing education.

9. Renewing professional enthusiasm.

ABILITY OF CONTINUING EDUCATION TO FULFILL ROLES

There were differences of opinion both within and among professions about whether continuing education as it presently exists is able to fulfill adequately its major roles, perceived as being roles 1 to 4 listed on the previous page. Three distinct points of view were put forward. Supporting arguments are presented below under each of the three headings. In summary, it can be said continuing education as it presently exists is addressing all roles in part but is not adequately fulfilling every role in all professions.

1. Uncertainty.
   Several respondents were uncertain about whether continuing education as it presently exists is able to fulfill its major roles. Points raised included:
   a) The major presumption underlying all continuing education undertakings is that participating in continuing education activities will lead to improvements in health care. No measures exist to determine whether participation in continuing education has any influence on the quality of care, and therefore, it is not possible to say whether or not this presumption is correct.
   b) There is similar difficulty in determining the relationship, if any, between continuing education and professional competence (the ability to provide care) even when it is examined separately from the health care provided. Several of the professions do not have clearly defined standards against which competence can be assessed. Only rarely are the standards that do exist being linked with continuing education in a way that would allow judgements to be made about whether continuing education is actually able to maintain and enhance professional competence.
   c) With respect to individual health professionals, only limited attempts are being made to determine whether those in need of improvement are participating in continuing education activities and whether those who do participate need what is being provided.

2. Agreement: Major Roles Are Fulfilled.
   Respondents in several professions felt continuing education as it currently exists in their profession is able to fulfill its major roles. In no case, however, was this view unanimous among all members of the profession interviewed. The major points raised included:
   a) Sufficient numbers and types of continuing education opportunities appear to exist to enable it to fulfill its fundamental role (maintaining and enhancing competence) on an over-all basis.
   b) The major roles are being fulfilled at least for those in larger centres.

3. Disagreement: Major Roles Are Not Fulfilled.
   The majority of respondents felt continuing education as it presently exists is unable to fulfill the roles outlined. Reasons given and points raised included:
   a) Access Factors
      i) Many health professionals have limited access to continuing

education programs because their numbers are small and they are geographically remote from centres where continuing education opportunities are provided. It is costly and time-consuming for them to travel to attend the continuing education programs, and their small numbers and wide geographic distribution makes it difficult for providers to deliver programs to them. This applies both to health professionals in small and isolated communities and to specialists in larger communities.

ii) Other factors limiting access are demanding work schedules, shift work and competing roles (e.g. family responsibilities).

b) Cost Factors

Cost was cited as a major barrier preventing continuing education from fulfilling its roles. Points raised included:

i) Leave with pay may not be provided. The individual professionals may not be able to afford to take leave without pay.

ii) Funds may not be available for replacement personnel.

iii) Funds for travel accommodation and tuition may not be available.

iv) Delivering programs to the professionals in small communities may not be cost-efficient because their numbers are small and locations diverse.

v) Where intensive programs are required, it may be difficult for continuing education providers to obtain the funds for program development and teaching personnel. If development funds can be obtained, cost factors mentioned above may create uncertainty about whether enrollment will be high enough to generate sufficient tuition revenue to cover operating costs.

vi) Funds spent by individuals on continuing educaton are discretionary dollars. Therefore, continuing education must compete with other priorities; family expenses, vacations, etc.

c) Programming Factors

i) The relevance and timeliness of continuing education programs is a problem. When the need for some particular knowledge or skill occurs, an appropriate educational program is usually not available to respond to the need at that time.

ii) A need is perceived for programs of various types that are not available for all professions requiring them at the present time; e.g. re-entry and refresher programs, extensive long-term programs in specialty areas, programs leading to higher professional qualifications, and comprehensive clinical programs.

d) Manpower Factors

i) Replacement personnel with appropriate qualifications and experience may not be available.

ii) Program development and instructional personnel with the appropriate qualifications in their health care field and in educational design and instruction may not be available to plan, teach, and evaluate the necessary programs.

e) Information Factors

i) Many health professionals are inadequately informed about continuing education opportunities available because no comprehensive systematic means of distributing information exists.

ii) Information about programs is often provided with insufficient lead time to enable prospective participants to make the necessary arrangements to attend.

iii) Publicity about continuing education programs frequently provides insufficient information to enable potential participants to judge their relevance to their practice.

f) Attitudinal/Motivational Factors

i) Some health professionals feel they learned all they need to know in their basic programs and, therefore, have no intention of participating in any form of continuing education.

ii) Unsatisfactory continuing education experiences may have "turned off" some health professionals who no longer participate as a result.

For both categories of people, continuing education can play no role, and even their basic competence may be substantially eroded.

g) Other Factors

i) There are more than 37,000 health professionals in British Columbia in the professions being considered. Each is at a different level than the others. It is impossible for the providers of continuing education to provide sufficient learning opportunities of a kind, in a place, and at a time that would meet the multiplicity of learning needs.

ii) In the smaller professions, there is a shortage of expert resource people to teach continuing education programs.

RELATIONSHIP OF CONTINUING EDUCATION TO POSSIBLE PAID EDUCATIONAL LEAVE

AVAILABILITY OF PAID EDUCATIONAL LEAVE

1. Provisions for Leave.

No universal system of educational leave exists in any of the professions. Where educational leave is available, it is not necessarily leave with pay. Provisions for leave that do exist take a variety of forms most of which apply to the members of several professions. The only profession for which no system of leave or assistance for leave appears to exist is Dentistry (with the exception of salaried Dentists who make up only about 5% of the population). The major ways in which provisions for educational leave exist are outlined below.

a) Union Contracts

Union contracts which include specific clauses relating to educational leave. Such contracts apply only to some members of the following professions: Audiology, Speech Language Pathology, Human Nutrition and Dietetics, Nursing, Pharmacy, Occupational Therapy and Physiotherapy. In most cases, the leave provided is of short duration, generally less than 10 days per year. Leave with pay is not guaranteed in all cases. Related expenses: tuition, travel, accommodation, etc. may or may not be provided.

b) Agreements for Faculty in Educational Institutions

Educational institutions usually have agreements by virtue of which health professionals who are faculty members have access to leave. These agreements may or may not be contractual in nature. Types of leave provided include study leave ("sabbaticals") for extended periods, typically up to one year at intervals of several years. Such leaves may be with part salary (e.g. 60% or 75% at the University of British Columbia depending on length of prior service) or with no salary (e.g. "professional development leave" at the British Columbia Institute of Technology). Such institutions also typically have arrangements for leaves of shorter duration. Again, these may be with or without pay.

c) Agreements with Major Employers Other Than Hospitals and Educational Institutions

Major employers of health professionals such as the Workers' Compensation Board and the Provincial Government usually have written agreements that include provisions for educational leave. The terms and conditions vary considerably. The agreements may or may not be contractual in nature.

d) Individual Negotiation

Employee professionals not covered by contracts or other formal arrangements frequently negotiate educational leave with their employers on an individual basis. The leaves may or may not be with pay, and associated costs may or may not be paid by the employer.

e) British Columbia Medical Education Fund

Physicians in British Columbia have access to monies for educational purposes from the B.C. Medical Education Fund. This fund, which is unique in Canada and possibly in North America, is described in some detail in Section II ("Medicine") of this report. It was set up in

lieu of a fee increase and therefore cannot be considered a system of paid leave in the usual sense. However, it does provide assistance to doctors who participate in continuing education activities.

2. Access to Leave.

It was found even though provisions for educational leave (paid or without pay) appear to exist for at least some members of most professions, access to leave is not uniformly available even for those to whom specific contractual provisions apply. Reasons given include:

a) Economic Recession

During the current economic recession, educational leave has been drastically curtailed in most professions. Where the granting of leaves involves obtaining approval, in some cases special processes have recently been established that make leave virtually impossible to obtain.

b) Wording of Agreements

Prior to the recession, leave was not uniformly accessible even to those who appeared to have a right to the leave. The wording of contracts or agreements implied the leave was to be granted at the discretion of the employer and frequently approval was not obtained. Phrases such as the following are typical:

i) "Such leave and reasonable expenses associated with the leave shall be subject to the approval of the Employer, who shall make every effort to grant such leave."[1]

ii) "Leave of absence and reasonable expenses with pay will be granted for education programs subject to the approval of the employer."[2]

c) Individual Negotiation

Where leaves can only be obtained through negotations with individual employers because of the absence of an agreement or contract, access to leave varies considerably and is seen as being limited.

d) Replacement Personnel

Reasons given for refusal of leave frequently relate to the availability of and costs associated with replacement personnel.

e) Geographic Remoteness

Access to leave is more difficult for health professionals in small or remote communities than for their colleagues in major centres. Replacement personnel (availability and costs) and the added time and expense associated with travel are the principal reasons given.

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[1] Master Agreement. January 1, 1980 - March 31, 1982. The Health Sciences Association of British Columbia and Health Labour Relations Association of British Columbia representing Member Hospitals and Health Organizations. Article 17.01 (b), p.24.

[2] Collective Agreement. January 1, 1980 - March 31, 1982. between Health Labour Relations Association of B.C. and Registered Nurses' Association of B.C. Labor Relations Division. Article 33.01, p.32.

OPINIONS ABOUT PAID EDUCATIONAL LEAVE

1. Desirability.
   a) It was agreed by representatives of all professions except Dentistry a universal system of paid leave for continuing education purposes would be desirable.
   b) The argument raised most frequently in support of this position is that improved health care would result. This argument is developed more fully and other points raised are listed below under the heading "Perceived Benefits."
   c) Other arguments raised are not specifically "benefits" included the following:
      i) Businesses allocate a specified portion of budget to maintain physical resources (physical plants and machinery). Maintenance of personnel resources is not budgetted in a similar manner. This seems unreasonable, given the large portion of health care budgets devoted to personnel. A system of universal paid educational leave appears to be a logical business investment.
      ii) If part of a person's job is maintaining and updating skills, it seems unreasonable to expect them to do this job without pay.

2. Advisability.
   Many of those who felt a universal system of paid educational leave was desirable expressed reservation about whether it was advisable. Their chief concern was the possible large costs such a system might entail. They stressed this point was vital at present because of grave concerns in all sectors of the community about the rising costs of health care. This point and other concerns raised are listed below under the heading "Perceived Problems and Concerns."

3. A Dissenting View.
   It was clearly agreed by those interviewed that a universal policy of paid educational leave for Dentists is NOT desirable. Reasons given included:
   a) The government should not pay private business for education leave, although additional tax credits might be considered.
   b) Continuing professional education is the responsibility of the individual practitioner.
   c) Lack of access to continuing education opportunities by professionals in remote or smaller communities does not present the same problem in Dentistry as in other professions:
      i) A network of continuing education co-ordinators exist who plan courses in and for local communities.
      ii) Alternative forms of continuing education exist for this purpose: home viewing of televised programs broadcast via satellite, and a videotape rental or sales system.
      iii) The College of Dental Surgeons provides funding for travel of speakers into smaller communities on a per capita basis (the fewer the number of dentists, the larger the portion of expenses that are paid).

The profession feels it has a system in place that in its view is coping effectively with the problem of continuing education for its members. The intervention of an outside party in a system that is working well at present would not be welcomed.

PERCEIVED BENEFITS

Most points raised in support of a universal system of paid educational leave related either directly or indirectly to anticipated improvements in the quality of health care that were expected to result. Specific points raised in this regard, and others, are listed below.

1. Quality of Health Care.
   Canadian geography places professionals in isolated situations that may mean a lower level of health care is provided in the communities which they service. This is not consistent with current thinking by virtue of which all people should have access to the same level and quality of services. A system of paid educational leave would help considerably in enabling continuing education to maintain and enhance the competence of all health professionals, thereby ensuring a uniform high level of care in all areas.

2. Increased Participation.
   Participation in continuing education is essential to maintain competence. Lack of participation does not produce a static condition. Erosion of competence occurs which accelerates the obsolescence caused by the rapid pace of growth of scientific knowledge in all areas of health sciences. Major barriers to participation (loss of salary, costs of replacement personnel, travel and accommodation costs, tuition fees, etc.) could be diminished considerably if not removed entirely by a universal system of paid educational leave. This would likely result in more frequent participation by those presently attending continuing education programs and would encourage participation by those not attending at present.

3. Improved Access.
   Inequities exist at the present time in terms of the ability of health professionals to obtain access to continuing education programs. These inequities relate to geographic location, types of employment situations and present provisions for leave. A universal system of paid educational leave would help to diminish inequitities and to equalize access opportunities.

4. Professional Growth and Development.
   A system of paid educational leave could foster the development of an attitude among health professionals that life-long learning is an integral part of a professional career. Such an attitude would facilitate the professional growth and development of the individuals concerned and enhance the quality of the care they provide.

5. Benefits to Educational Providers.
   A universal system of paid educational leave could lead to an unprecedented acceleration in the demand for continuing education programs and related research activities. This demand, accompanied by support from government

and employers could create a stable funding base and a predictable market for continuing education programs that would allow for long-range planning by educational providers, greater diversity of programs and a new system of delivery.

6. Development of Needed Programs.

Continuing education programs at present tend to be mainly of short duration. They provide an overview and introduction but cannot provide the level of knowledge and skills required by health professionals undertaking new roles or moving into different practice areas. In some cases, the required program content is not included in basic programs at all: e.g. certain speciality practice areas, management and administration, and educational design and teaching. A universal system of paid educational leave could assist with the development of the needed longer-term programs, at least by ensuring the demand. It would also help to ensure such programs were accessible to those who need them by easing the financial burdens associated with long-term study, including relocation costs for some.

7. Benefits to Employers and Employees.

a) It was argued that investments in the form of paid educational leave would be recognized and appreciated by the recipients, leading to the following benefits, among others:
   i) Improved employer-employee relations.
   ii) Increased job satisfaction.
   iii) Accelerated professional growth.
   iv) Increased productivity.
   v) Increasing willingness to accept and initiate change.
   vi) Lower levels of staff turnover.

b) It was argued further these and other similar benefits could compensate for dollars spent on paid leave through increased efficiency and productivity and reduced costs of recruitment, training and retraining.

PERCEIVED PROBLEMS OR CONCERNS

1. Economic and Financial.
   a) Almost every respondent indicated a concern about the apparent tremendous cost of a system of universal paid educational leave. It was pointed out a number of types and levels of funding would be needed to develop and implement an effective system. Funding would be required:
      i) To develop standards of care or levels of stated competence where these do not exist at present.
      ii) To develop and implement the continuing education programs required to enable the professionals to meet the standards. Costs here could include physical facilities.
      iii) To evaluate program quality.
      iv) To enable professionals to participate (their costs and costs of replacement personnel).
      v) To assess the competence of the individuals and the quality of care.
   b) Loss of income to employers through lost patient contact during the absence of their professional employees was identified as a cost factor that should be considered.
   c) It was pointed out recipients of paid educational leave might want to link participation in continuing education programs with increases in salary or professional fees, thus introducing an additional inflationary cost factor.
   d) The countervailing view was expressed that on an over-all basis there might be only the appearance of added costs and that resultant benefits would actually offset any such costs. For example, lower turnover of staff would reduce recruiting, orientation and training costs. It was pointed out this is the actual experience of one B.C. hospital which has maintained its policy of granting educational leaves in spite of the current recession.

2. Replacement Personnel.
   a) In smaller and remote communities, the availability of appropriately qualified replacement personnel was identified as a serious concern. The extent of the problem would be related to the duration and frequency of the leaves, which would have to be structured so as to ensure the quality or availability of care was not reduced to an unacceptable level.
   b) In all situations, funding for replacement personnel is seen as the largest single cost factor associated with a system of paid educational leave.

3. Educational Considerations.
   a) Implementing a system of paid educational leave might create a sudden, dramatic increase in the demand for continuing education programs. Continuing education providers would have difficulty responding to this demand with appropriate programs of high quality if this were expected to be done with existing personnel, facilities and financial resources.
   b) The following steps would be required in order to ensure the availability of sufficient numbers and types of high quality programs:
      i) Funding, personnel and physical resources would have to be provided to cope with the increased demand a paid leave system would create.

ii) Personnel would have to be prepared to develop and teach programs.

iii) Facilities not available for continuing education purposes in educational institutions at present would have to be made available.

iv) A system of evaluation would have to be put in place to evaluate outcomes at the various stages of the process: learning, competence, performance.

v) A system would have to be created to ensure programs of consistently high quality were being offered by all providers and duplication was avoided.

vi) A system would have to be established to obtain informed consumer input into program development to ensure the programs were relevant to the real educational needs of the professionals for whom they are planned.

c) If public funds were directed into a system of paid educational leave, the nature of continuing education should be scrutinized and where appropriate, should be expected to change. In the past, continuing education has tended to be short-term and specific, relating to particular tasks and functions. With a system of paid leave, it should also be expected to embrace broader concepts, allowing for systematic and sequential planning for career development, role change, etc.

d) Delivery systems for continuing education would have to be examined to ensure the most efficient and effective systems were being used. Non-traditional approaches and new technology would have to be considered and introduced where appropriate to ensure funds were not being spent on needless travel by individual professional learners.

4. Employment Security.

Concerns were expressed on behalf of both the employer and the employee in this regard:

a) Health professionals might not wish to return to their original employment situtation after an extended leave.

b) Positions may have changed or have been closed during the period of the leave so the original position is no longer available when the health professional returns from leave.

5. Role Conflicts.

Many members of the health professions are women who have dual careers: family roles and professional roles. They may not be able to leave their communities for systematic short-term leaves. It is highly unlikely they would be able to get away for leaves of long duration.

6. Disruption to Families.

A system of leave could cause disruption and even hardship for families, particularly where absences are prolonged. Special consideration may have to be given and additional resources applied in such situations to allow for housekeeping services, return visits home, long distance telephone costs, etc.

7. Taxpayer Resistance.

Resistance to a system of paid leave could be generated by the taxpayers who might have difficulty seeing the benefits as clearly as the costs.

8. Potential Abuses of the System.

a) Concern was expressed that people might obtain or seek to obtain leave for inappropriate purposes and if granted leave they might not attend the programs or might not participate in a meaningful way.

b) The countervailing view was expressed that abuses could be diminished by a monitoring or reporting system and by having the professionals bear a portion of the costs.

9. Implementation Concerns.

A considerable number of questions and concerns were raised relating to the implementation or administration of a system of paid educational leave. Among them were:

a) Guidelines would be required to respond to such issues as: How much time? At what intervals? For what purposes? What types and levels of payment?

b) How would the system apply to self-employed professionals?

c) In whose hands would responsibility for administering the system lie: professional bodies? government?

d) How would the over-all effectiveness of the system be assessed? Ongoing research was seen as essential to determine whether the system was having a positive impact commensurate with its costs.

e) If universal paid educational leave were made available, would participation in continuing education become mandatory as a result? If an individual chose not to participate, would his competence be questioned? If so, how and by whom would his competency be assessed?

RELATED CONSIDERATIONS

1. Professional Accountability.

Views were expressed about financial accountability and about accountability in terms of competence.

a) It was agreed by all that health professionals should be expected to bear a portion of the costs of continuing professional development.

b) What portion of the costs should be paid by the professional and what portion from other sources was not agreed. Some suggestions were:

i) Time off with pay might be provided for a specified minimum number of days. Days in addition might be without pay. Related costs: travel, tuition, etc. could be shared on a negotiated basis.

ii) In Pharmacy, where a "Competency Assessment Project" exists, it was suggested individual Pharmacists should bear the costs associated with maintaining basic competence. Costs of other continuing pharmacy education should be borne by the employer because of the benefits which would flow to the employer as a result of improved performance.

iii) If continuing education is mandatory, it was suggested sufficient time with pay should be provided to meet the mandatory requirement. Time beyond the requirement should be the responsibility of the professional.

iv) Several approaches to cost-sharing were suggested:
- Professionals bear one-third of the cost
- Costs be shared 50:50
- Professionals pay tuition fees and some travel costs but receive time off with pay.

v) It was pointed out professionals are bearing a portion of the cost at present through professional fees, some of which are used to support continuing education activities.

vi) If tax dollars are used to support paid leave, part of the professional's responsibility is met because of taxes paid.

vii) Several respondents suggested the professionals should bear the costs of professional journal subscriptions.

viii) Most respondents suggested where participation in continuing education activities is required by the employer, all costs should be borne by the employer.

ix) The view was expressed if paid educational leave becomes a right, health professionals should expect to be accountable for the results of the educational process through examinations or assessment of competence.

2. Universality.

a) It was agreed if a system of paid educational leave is instituted, its benefits should be universally available to health professionals regardless of their geographic location or type of practice.

b) It was pointed out such a system should apply to all health personnel, and not only to those professions referred to in this submission.

c) Concern was expressed about the unique or special needs of certain categories of professionals:
   i) The unemployed
   ii) Single parents or widows/widowers suddenly forced to return to the market place
   iii) The disabled.

3. Administration of the System.
Several specific suggestions were made with regard to administration of a system of paid leave, if one were implemented:

a) Structure of Leaves
It was suggested leaves should be structured so continuing education is concurrent with rather than separate from professional practice. This could be accomplished by part-time or short-duration leaves at regular intervals, allowing for the integration of new learning into clinical practice. This would also make continued learning an ongoing expectation.

b) Flexibility
It was recommended the system have flexibility to cope with needs for programs of varying length and with the varying needs of individual professionals. A "banking" system would be useful to enable people to take longer leaves. Flexibility would also be helpful so vacations and other benefits could be combined to provide extended leaves.

c) Monitoring Systems
It was felt to be important the system be carefully monitored and responsibility for monitoring be shared and clearly defined.
   i) Educational institutions should be responsible for monitoring the quality of programs and the educational outcomes.
   ii) Professional associations should be responsible for monitoring the quality of health care and performance outcomes.

d) Other Suggestions
   i) The needs of remote health professionals could be better served by changing delivery systems for continuing educatin so learning opportunities were available in or near their communities. It would be more efficient to make funds available to continuing education providers for this purpose than to pay travel costs for health professionals.
   ii) Educational leave should be linked to the results of performance appraisals, where appropriate.
   iii) The concept of "sabbatical leave" as it is understood in educational institutions should apply to health professionals to allow for extended study, clinical traineeships, etc.
   iv) The language of existing contracts should be refined and clarified and relevant provisions enforced so the educational leave provisions are equally available to all those covered by the contract.

4. Funding Mechanisms.
Several specific suggestions were offered about ways in which funding for a system of paid leave could be obtained and/or administered.

a) Self Employed Professionals
The B.C. Medical Education Fund was recommended as a model for professionals employed on a "fee-for-service" basis. It is described in Section II ("Medicine") of this report.

b) Pharmacists

Many prescriptions are now handled under the provincial government's Pharmacare program. A few cents of the cost of each prescription could be set aside in a fund for continuing education purposes. A similar system is already in place in which a few cents per prescription provide funding for furthering the activities of the B.C. Pharmacists' Society.

c) Professional Associations or Licensing Bodies

In some cases, professional associations or licensing bodies are empowered to levy fees to produce funds specifically for continuing education purposes. Such a system was not recommended as the entire "answer" to the problem of funding for paid leave.

d) Income Tax Concessions

i) It was suggested changes could be made in income tax laws to relieve some of the costs of participating in continuing education. For example, employee professionals might be given access to concessions presently available to self-employed professionals. The implications of such a system for other employees were noted as being considerable.

ii) Agreed health professionals should be made fully aware of income tax concessions to which they are entitled at present.

5. Other Issues.

a) Research Requirements

It was strongly recommended the development of a system of paid educational leave be accompanied by appropriate research initiatives to ensure its efficiency and effectiveness:

i) Analysis of relationships between participation in continuing education and improvements in the quality of care.

ii) Analysis of participation to ensure those who need improvement are participating in continuing education.

iii) Analysis of learning needs (competence?) to ensure continuing education being provided is congruent with needs.

iv) Cost-benefit analysis of the system as a whole to determine whether paid leave is cost-effective.

b) Health Manpower Planning

The view was expressed health manpower planning groups should be encouraged to provide more precise data with regard to demand for refresher programs and for skills training in specialized areas. Communication links should be established with continuing education providers so current data can be used to predict educational needs and to develop timely programs.

c) An Important Alternative Point of View

It was suggested perhaps funds should not be spent on paid educational leave but rather on increasing the supply of health professionals to provide the care. Professionals are too busy to provide the care they have been trained for. A comprehensive approach to treatment seems to have been replaced by a functional (fragmented) approach as a result.

CONCLUSIONS

1. Continuing education for health professionals has specific roles that can be clearly delineated and are of significant potential importance to the health and well-being of British Columbians.

2. Continuing education as it currently exists is not fulfilling the stated roles adequately for the majority of health professionals in B.C.

3. Paid educational leave is an important potential means of improving the ability of continuing education to fulfill its stated roles.

RECOMMENDATIONS

1. That the feasibility of implementing a universal system of paid educational leave for health professionals be studied in greater depth.

2. That all interested parties: health professionals, professional associations, licensing bodies, educational providers, employers, government, and members of the public be given an opportunity to contribute to the study.

3. That due consideration be given to the need for research and evaluation prior to, concurrent with, and following the implementation of a system of paid educational leave, with particular attention being paid to relevant economic factors.

4. That immediate attention be directed to existing provisions for paid leave where they exist in written form with a view to ensuring that the wording reflects the actual intent and that the provisions are in fact made accessible to those to whom they apply.

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SECTION II

THE INDIVIDUAL HEALTH PROFESSIONS

AUDIOLOGY AND SPEECH SCIENCES

DEFINITIONS

1. An Audiologist:

"Provides diagnostic evaluation and rehabilitative services and conducts research related to hearing.
Administers air and bond conduction and other audiometric tests and examinations to determine hearing efficiency. Co-ordinates audiometric results with medical, social, behavioural and other diagnostic data. Evaluates total response pattern and acoustic tests to differentiate between organic and non-organic hearing loss. Plans, directs and participates in counselling, speech reading and other rehabilitation programs. Acts as consultant to educational, medical and other professional groups. Conducts research in physiology, pathology, biophysics and psychophysics of auditory system, if required. Designs and develops clinical and research procedures and apparatus, if required."[1]

2. A Speech Pathologist:

"Diagnoses and treats speech, language and voice disorders, and performs related research.
Administers tests and observes patient to diagnose nature of disorder and to evaluate degree of impairment. Plans and conducts remedial exercises and programs to correct stuttering, abnormal articulation and other disorders. Provides speech training for patient with communication problems caused by cerebral palsy, surgical removal of larynx, hearing deficiencies or other impairments. Plans individual or group therapy in rehabilitation of communication disorders. Counsels and guides language-handicapped individuals and their families, teachers or employers. Acts as consultant to educational, medical, dental and other professional groups. Conducts research related to development of diagnostic and treatment techniques and procedures, or design of apparatus."[2]

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[1] Canadian Classification and Dictionary of Occupations 1980. Major Group 31, No. 3137-110, p.55, Ottawa: Employment and Immigration Canada.

[2] Ibid., No. 3137-114.

APPROXIMATE NUMBERS

In September 1981, 209 Audiologists and Speech Language Pathologists were active or associate members of the B.C. Speech and Hearing Association.[1]

TYPES OF PRACTICE [2]

1.	Audiologists	
	Public Health Units	46%
	Hospitals	27%
	Workers' Compensation Board	27%
		100%
2.	Speech Language Pathologists	
	Public Schools	52%
	Public Health Units	25%
	Hospitals and Rehabilitation Centres	16%
	Private Practice	7%
		100%

FORMS OF CONTINUING EDUCATION

1. Audiologists
   a) Short courses and workshops (1 - 2 days)
   b) Special lectures (1 - 2 hours)
   c) Conferences with associated educational events
   d) Lecture series for other professionals with some Audiology content
   e) Study Groups (bi-monthly evening meetings).

2. Speech Language Pathologists
   a) Short courses and workshops (1 - 2 days)
   b) Conferences with associated educational events
   c) In-service training in hospitals or agencies for other professionals (limited relevant content).

MANADATORY CONTINUING EDUCATION

1. Continuing education is not mandatory for Audiologists or Speech Language Pathologists in British Columbia at the present time.

2. Compulsory registration and/or licensure does not exist.

3. Membership in the B.C. Speech and Hearing Association is voluntary.

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[1] ROLLCALL '81, p.1-1 (see References).
[2] Percentage figures are gross estimates only, provided by interviewers.

ROLES OF CONTINUING EDUCATION

For both professions:

1. Maintaining basic competence is seen as a major issue in both professions. In the absence of a comprehensive program of continuing education, competencies may be being eroded.

2. Acquiring new knowledge and skills.

3. Facilitating role changes.
   e.g. Audiologists. Expanding into aural rehabilitation whereas previous role was diagnosis. Some practices now include hearing aid fitting and dispensing.
   e.g. Speech Pathologists. Changes from paediatric to adult care settings or from public schools to hospitals.

4. Professional advancement.
   Relevant only where credit courses are available.

5. Renewing professional enthusiasm.

ABILITY OF CONTINUING EDUCATION TO FULFILL ROLES

It was agreed continuing education as it is presently available is unable to fulfill the roles outlined above. Some reasons are:

1. Access Factors
   a) The number of continuing education programs currently available is too small for the roles to be fulfilled.
   b) Practitioners are spread over a wide geographic area. Difficult for them to travel to major centres and/or to deliver programs to them.

2. Cost Factors
   a) Number of professionals is so small and locations so diverse, it is difficult to plan programs that will cover their costs.
   b) Leave with pay may not be provided.
   c) Funds for replacement personnel may not be available.
   d) Funds for travel, tuition, etc. may not be available.

3. Personnel Factors
   a) Replacement personnel are not likely to be available to cover extended leaves.
   b) Personnel to plan continuing education programs are limited.

AVAILABILITY OF PAID EDUCATIONAL LEAVE

It was generally agreed that:

1. Paid leave had been available to an extent for short term educational programs prior to the current economic recession, but was not universal.

2. Leaves were granted at the discretion of employers in most cases. The availability of paid leave varied within and among categories of employers.

3. Where contracts existed, provisions relating to paid leave were often ambiguous and/or not enforced.

4. Where Audiologists and Speech Pathologists were members of unions the majority of whose members were not professionals, no paid leave was included in the contracts.

5. The availability of paid leave for professionals in small or remote communities was limited because of travel costs and the availability and cost of replacement personnel.

6. Extended leaves with pay were rare, if available at all.

7. During the current economic recession, paid leave has been significantly curtailed and in many cases is no longer available at all.

RELATIONSHIP OF CONTINUING EDUCATION TO PAID EDUCATIONAL LEAVE

DESIRABILITY OF PAID LEAVE

Agreed universal paid educational leave should be available to Audiologists and Speech Pathologists for continuing education purposes.

PERCEIVED BENEFITS

1. Professional growth would be facilitated. Improved job performance and an improvement in the over-all quality of health care would result.

2. Job satisfaction would be increased because the individual professional would perceive the employer's investment as a recognition of his/her value. Staff turnover would be reduced as would recruiting, training and retraining costs.

3. Access to continuing education opportunities would be equalized across all professionals regardless of size and location of community or type of practice. Progress would therefore be made toward a uniform, high standard of care in all areas.

4. Professionals in small or remote communities as well as refreshing and updating knowledge and skills would be able on a systematic basis to build and reinforce vital support systems of consultations and contacts among their colleagues.

PERCEIVED PROBLEMS OR CONCERNS

1. Economic and Financial
   a) Loss of income for employers through lost patient contacts during leaves.

b) Cost of replacement personnel.
c) Disproportionate travel costs for those from small and remote communities.
d) If paid leave were made universal funds would have to be made available to continuing education providers for program development and personnel.

2. Access to Programs
a) How to deliver continuing education to widely dispersed professionals, few in numbers on a reasonably efficient, cost-effective basis.
b) How to enable professionals to travel to continuing education events outside their commlunities without incurring unreasonable costs or diminishing to an unreasonable extent the quality of health care during their absence.

3. Role Conflicts
Most members of these professions are women who have dual careers: family roles and professional roles. They may not be able to leave their communities for systematic short-term leaves. It is highly unlikely they would be able to get away for leaves of long duration.

RELATED CONSIDERATIONS

1. Professional Accountability
a) Agreed the professionals should bear a portion of the cost of professional development.
b) Time off with pay might be provided for a specified minimum number of days. Days in addition might be leave without pay. Related costs: travel, tuition, etc. could be shared on a negotiated basis. Professionals should pay subscription costs for journals.

2. Professional Standards
a) A significant problem in Speech Pathology at present is the current acceptable qualification is a Master's degree. A significant number of practitioners, particularly in outlying areas, hold only bachelor's degrees. Their mobility and ability for professional advancement is curtailed. Paid leave is necessary for them to be away the length of time necessary to take credit courses.
b) The Association is raising the required standard for membership to include specific courses. To take these courses may require lengthy absence from work. The new standards are not a legal requirement, and membership in the Association is voluntary, but most employers are using the standards as guidelines. Some present practitioners may no longer be able to continue working.
c) Mandatory continuing education is being considered by the Association. If it is instituted, paid leave would become essential, particularly if membership in the Association became a requirement for licensure.

DENTISTRY

This portion of the submission will include Dentists and Dental Hygienists.

DEFINITIONS

1. A Dentist:

"Diagnoses and treats diseases, injuries and malformations of teeth, gums and related oral structures and prescribes and administers preventive procedures. Examines teeth, gums and other tissues using X-rays and dental equipment. Diagnoses condition and plans treatment. Administers local or general anaesthetic. Fills cavities with amalgam, silver, gold, or other material. Replaces portion of tooth crown with inlay or artificial crown. Performs minor oral surgery, including extractions of erupted or impacted teeth. Takes dental impressions. Designs bridgework and partial or complete dentures. Constructs dental appliances or writes specifications for dental technician. Cleans teeth. Instructs patients in oral hygiene to prevent dental problems. Monitors growth pattern of patient's teeth. Refers patients to specialists."[1]

2. A Dental Hygienist:

"In addition to the duties and technical procedures performed by dental assistants and certified dental assistants,[2] "the following duties and technical procedures may be delegated... to a Registered Dental Auxiliary II (Dental Hygienist) under the direction of a licensed Member (of the College).

- The examinations of the head and neck as it pertains to dentistry.
- The examination of the intra-oral structures.
- The taking of pulp vitality, tests.
- The placement and removal of temporary restorations.
- The application and removal of periodontal dressings.
- The removal of supra and subgingival calculus.
- The curettage and root planning of tooth surfaces.
- The recontouring of existing restorations.
- The desensitization of existing restorations.
- The desensitization of hypersensitive teeth.
- After the successful completion of approved training, and performed only under the personal supervision of a licensed Member, the administration of local anaesthetics."[3]

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[1] Canadian Classification and Dictionary of Occupations 1980. Major Group 31, No. 3113-134, p.50, Ottawa: Employment and Immigration Canada.

[2] Regulations of The College of Dental Surgeons of British Columbia, Ancillary Bodies, revised March 1981, Sections 82 and 83.

[3] Regulations of The College of Dental Surgeons of British Columbia, Ancillary Bodies, revised March 1981, Section 85.

APPROXIMATE NUMBERS

In September 1981, 1670 Dentists and 448 Dental Hygienists were licensed by the College of Dental Surgeons of British Columbia.

SPECIALITIES AND TYPES OF PRACTICE

1. Specialties - Dentists
   Licensed Dentists are certified by the College of Dental Surgeons in the following categories:
   a) Non-Specialist
   b) Endodontics
   c) Oral and Maxillofacial Surgery
   d) Orthodontics
   e) Pediatric Dentistry
   f) Periodontics
   g) Prosthodontics
   h) Oral Pathology.

2. Specialties - Dental Hygienists
   This profession is not subdivided into specialty practice areas. Related categories of dental personnel are non-registered chairside dental auxiliaries (dental assistants) and Registered Dental Auxiliary I (Certified Dental Assistant). Dental Hygienists are classified as Registered Dental Auxiliary I by the College of Dental Surgeons of British Columbia and may perform the duties and technical procedures of the other two categories.

3. Types of Practice - Dentists[1]

a) Fee For Service		95%
- Solo	50%	
- Group	25%	
- Associateship	20%	
b) Salaried Dentists		5% or less
		100%

4. Types of Practice - Dental Hygienists[1]

Salaried (monthly)	35%
Per diem	60%
Independent contractors	5%
	100%

[1] Percentage figures are gross estimates only, provided by interviewees.

FORMS OF CONTINUING EDUCATION

1. Dentists.
   a) Short courses (didactic) 1 to 5 days
   b) Clinical courses and study clubs (1 to 2 day events or regularly scheduled series)
   c) Videotape sales and rentals
   d) Telvised programs via satellite.

2. Dental Hygienists.
   a) Short courses, 1 - 2 days (didactic or clinical)
   b) Televised courses via satellite
   c) Specialized courses, 3 - 6 days
   d) Study clubs (specialty groups meeting monthly for improving clinical skills)
   e) Local chapters of B.C. Dental Hygienists Association have monthly meetings with speakers
   f) Conventions
   g) Videotape: sale or rental.

MANDATORY CONTINUING EDUCATION

1. Dentists.
   a) In order to practice as a dentist in British Columbia, it is necessary to be registered by the College of Dental Surgeons and to hold a valid licence.
   b) Continuing education is mandatory for licensure in B.C. Each Dentist is required by the College of Dental Surgeons to participate in 90 hours of continuing education in a 3 year period. A written clinical examination is an option that may be substituted for continuing education.

2. Dental Hygienists.
   a) In order to practice as a dental hygienist in British Columbia, it is necessary to be registered by the College of Dental Surgeons and to hold a valid licence.
   b) Continuing education is mandatory for licensure in B.C. Each Dental Hygienist is required by the College of Dental Surgeons to participate in 75 hours of continuing education in a 3 year period.
   c) Membership in the British Columbia Dental Hygienists' Association is not compulsory.

ROLES OF CONTINUING EDUCATION

1. Dentists.
   a) Maintaining basic competence.
   b) Acquiring new knowledge and skills.
   c) Facilitating role changes, e.g. Dental practice is changing. For example, the incidence of dental caries has diminished considerably over the last decade. Treatment of caries is no longer a significant part of a dentist's practice. A shift is required into other types of practice (e.g. periodontics - prevention and treatment of gum disease). This will require clinical teaching to a greater extent.

d) Professional advancement, e.g. Masterships and Fellowships can be obtained in learned dental societies through continuing education.
e) Sharing of techniques and refinements among continuing education participants in a profession oriented to techniques.

2. Dental Hygienists.
a) Maintaining basic competence.
b) Acquiring new knowledge and skills.
c) Facilitating role changes, e.g. Moving into a speciality practice area or into a teaching position at University or College.
d) Socialization. Continuing education programs provide opportunities for informal interchange of ideas and for strengthening professional relationships.

ABILITY OF CONTINUING EDUCATION TO FULFILL ROLES.

1. Dentists.
Uncertainty was expressed about whether continuing education as it currently exists is adequately fulfilling the roles outlined above. Reasons given included:
a) No measure of competence exists and no means of measuring the impact of continuing education on competence. Therefore, it is not possible to know whether continuing education is in fact enabling Dentists to maintain basic competence.
b) In the opinion of some, more clinically-oriented courses are required to enable Dentists to acquire new skills and to facilitate role changes. However, this does not appear to be a demand for highly specialized clinical courses.

2. Dental Hygienists.
a) The major roles are fulfilled for Dental Hygienists in major centres but not for those in small or remote communities because of problems of access to continuing education opportunities.
b) Continuing education as it presently exists provides no means of re-entry for people out of practice. This would require more comprehensive programs with an extensive clinical component. At present such programs are not offered due to lack of faculty with sufficient time for program development.

AVAILABILITY OF PAID EDUCATIONAL LEAVE

1. Dentists.
a) Paid educational leave is available at present only to salaried dentists:
- Public health systems
- Other government service
- Universities (sabbatical and shorter term leave).
b) Non-salaried dentists, who make up 95% of the population have access only to income tax concessions.

2. Dental Hygienists
No uniform policy exists. Most hygienists negotiate arrangements on an individual basis with their employers.

RELATIONSHIP OF CONTINUING EDUCATION TO PAID EDUCATIONAL LEAVE

DESIRABILITY OF PAID LEAVE

1. Dentists.
It was clearly agreed by those interviewed that a universal policy of paid educational leave for Dentists is NOT desirable. Reasons given included:
   a) The government should not pay private business for education leave, although additional tax credits might be considered.
   b) Continuing professional education is the responsibility of the individual practitioner.
   c) Lack of access to continuing education opportunities by professionals in remote or smaller communities does not present the same problem as in other professions:
      i) A network of continuing education co-ordinators exist who plan courses in and for local communities.
      ii) Alternative forms of continuing education exist for this purpose: home viewing of televised programs broadcast via satellite, videotape rental or sales system.
      iii) The College of Dental Surgeons provides funding for travel of speakers into smaller communities on a per capita basis (the fewer the number of dentists, the larger the portion of expenses that are paid).

2. Dental Hygienists.
A policy of universal paid educational leave for Dental Hygienists is seen as desirable. Reasons given included:
   a) Since continuing education is mandatory, some provision should be made to facilitate participation. A policy of paid leave is one means of accomplishing this.
   b) Most Dental Hygienists as employee professionals do not have access to the same income tax concessions that are available to Dentists.

PERCEIVED BENEFITS

1. Dentists.
No benefits were named.

2. Dental Hygienists.
   a) Would ensure to a much greater degree than at present that mandatory continuing education helps to maintain competence.
   b) It would help to ensure equal access by Dental Hygienists to continuing education opportunities regardless of their location.

PERCEIVED PROBLEMS OR CONCERNS

1. Dentists.
   a) Economic and Financial
      i) The potential cost of a system of universal paid leave appear to be enormous.

ii) Participants might want to link participation in continuing education programs with increased fees. This would lead to an added inflationary cost factor.

b) Continuing education providers.
Sudden unreasonable levels of demand might be placed on continuing education providers who would be unable to respond with sufficient numbers and types of programs of uniform high quality.

c) Abuses of the System.
People might tend to obtain or seek to obtain leave for inappropriate purposes.

2. Dental Hygienists.

a) Replacement Personnel.
Providing replacements for those away at courses might be difficult and costly.

b) Educational Facilities - Clinical.
Increased demand for clinical programs would put increased pressure on clinical facilities. New facilities might be required.

RELATED CONSIDERATIONS

1. Dentists.

a) Professional Accountability.
The individual professional must bear the responsibility for much of his own professional development. Therefore, for non-salaried dentists, the most appropriate system appears to be one relating to income tax concessions.

b) Continuing Education Providers.
Continuing education providers must be included in planning for any scheme of paid leave. Increasing demand would have to be accompanied by increased resources to allow the educational system to respond effectively.

c) Professional Association.
The professional association has a system in place that in their view is coping effectively with the problem of continuing education for its members. They would not welcome the intervention of an outside party in a system that is working well at present.

2. Dental Hygienists.

a) Professional Accountability.
Continuing education should be a shared responsibility between the professional and the employer or government. Sufficient time with pay should be provided to meet the mandatory requirement. Time beyond the requirement should be the responsibility of the professsional.

b) Implementation Suggestion.
Tax concessions may be a feasible route. Dental hygienists should be made more aware of existing tax concessions. More concessions might be considered.

c) Access to Continuing Education Opportunities.
Travel and other expenses of professionals in smaller communities were seen as a problem. No specific recommendations were made.

HUMAN NUTRITION AND DIETETICS

DEFINITIONS

1. A Dietitian:

"Plans and supervises food service programs in governmental, institutional, and commercial establishments to provide nutritionally adequate quality food. Plans diets and menus, and evaluates clients' acceptance. Plans and submits budget, and manages and controls operating costs. Establishes and maintains standards of food productions and service, sanitation, safety and security. Supervises workers, and directs efficient use of personnel and equipment. Institutes measures to improve efficiency and quality of food service system. Plans, conducts, and evaluates orientation and inservice training programs. Determines food, equipment and supply requirements for new or renovated food services facilities. Prepares material on nutritional value of foods, methods of preparation and recipes, if required."[1]

2. A Nutritionist:

"Provides consulting services to community, and organizes, plans and conducts programs concerning nutrition to assist in promotion of health and prevention of disease.
Assesses nutritional needs and available resources of community. Develops and implements community programs concerning nutrition. Advises health and other agencies on nutritional and food service standards of their food programs. Counsels individuals and families in nutritional principles, diet, food selection, and economical buying practices. Interprets and evaluates current research relating to nutrition and food service systems management to public and to staff. Conducts or participates in in-service education. Plans, conducts and evaluates nutrition education programs for public. Prepares technical publications, and publications for the public concerning food and nutrition. Plans, conducts and evaluates dietary studies, and participates in studies of diseases with nutrition component. Plans or participates in funding programs, and recommends budget. Manages and controls financial resources."[1]

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[1] Canadian Classification and Dictionary of Occupations 1980. Major Group 31, No. 3152-122, p.60. Ottawa: Employment and Immigration Canada.

APPROXIMATE NUMBERS

In September 1981, 444 Dietitians and Nutritionists were members of The B.C. Dietitians' and Nutritionists' Association (BCDNA).[1]

TYPES OF PRACTICE [2]

Community Settings Public Health Teaching Positions	15%
Hospitals and Institutions	20%
Clinical Positions	45%
Out of Practice	20%
	100%

FORMS OF CONTINUING EDUCATION

The following are included in the BCDNA "Continuing Education Guidelines" (revised September 1982):

1. Lectures or addresses
2. Workshops, seminars, conferences, institutes
3. Commercial and educational exhibits
4. Observation study
5. Courses: academic and non-academic
6. Writing for publication
7. Teaching
8. Journal clubs
9. Grand medical rounds
10. Individual study.

MANDATORY CONTINUING EDUCATION

1. Compulsory registration and/or licensure does not exist.

2. Membership in the BCDNA is voluntary.

3. Continuing education is mandatory for membership in the BCDNA. Fifteen continuing education points are required each year, and a total of 75 points must be earned in a 5 year period.

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[1] ROLLCALL 81, p.10-4 (See References)
[2] Percentage figures are gross estimates only, provided by interviewees.

ROLES OF CONTINUING EDUCATION

For both professions:

1. Maintaining basic competence.

2. Acquiring new skills.

3. Facilitating role changes.
   e.g. If a dietitian changes hospital, the new situation may require her to diagnose and prescribe diet therapy on the basis of the patient's record.

4. Professional advancement (limited).
   Significant professional advancement is not available through continuing education in the usual sense because advancement opportunities in the field are limited. Those dietitians who are members of the Health Sciences Association have access to advancement through six grades relating to the supervision of others.

ABILITY OF CONTINUING EDUCATION TO FULFILL ROLES

Those interviewed did not agree on whether continuing education as it currently exists is adequately fulfilling the roles outlined above. Some points raised were:

1. Continuing Education and Competence.
   a) Quality assurance is just beginning in B.C. through tray audits and audits of medical records. However, as yet there is no comprehensive means of assessing competence.
   b) Professional standards are in the process of being developed, but are not yet established. This makes it even more difficult to relate continuing education to competence.
   c) Because the BCDNA is not a legal entity, continuing education participation cannot be enforced. Morever, it is difficult to determine what forms of continuing education are appropriate because members can submit events for credit which, if challenged, could not legally be refused.

2. Availability of Continuing Education.
   Sufficient numbers and types of continuing education opportunities appear to exist to enable it to fulfill the fundamental roles: maintaining and enhancing competence.

AVAILABILITY OF PAID EDUCATIONAL LEAVE

Those interviewed agreed that:

1. Paid educational leave is provided for in contracts which cover many Dietitians and Nutritionists; for example, those who are members of the Health Sciences Association and the B.C. Government Employees Union.

2. Paid leave is not universally available, even to members of unions whose contracts provide for it. In many cases it is granted at the discretion of the employer.

3. During the current economic recession, the availability of leave has been cut back drastically. Where it continues to exist "on paper" approval processes have been instituted in some cases which virtually preclude its being granted.

RELATIONSHIP OF CONTINUING EDUCATION TO PAID EDUCATIONAL LEAVE

DESIRABILITY OF PAID LEAVE

Agreed universal paid educational leave should be available to Dietitians and Nutritionists for continuing education purposes.

PERCEIVED BENEFITS

1. An enhanced level of professional competence would result, leading to improved service to the public.

2. Motivation of the employees would be enhanced. An improved spirit of professionalism between the employer and employee and among employees would result. These factors would lead to improved productivity.

3. Huge investments are being made in professional salary payments. Paid leave is a small necessary addition to maintain and enhance the investment and may result in savings by facilitating role changes and changes in procedures.

PERCEIVED PROBLEMS OR CONCERNS

1. Economic and Financial
   Over-all cost to the employers and the health care system.

2. Replacement Personnel
   It might be difficult to find appropriately qualified replacement personnel. The seriousness of the problem would depend on the provisions of a paid leave system: duration, frequency.

3. Quality of Educational Programs
   a) If universal paid leave were available, it would be incumbent on providers to make available programs of consistently high quality and to evaluate outcomes at all levels.
   b) Additional funds would be required for staffing, program development and evaluation and facilites.

4. Public Perceptions
   Members of the general public might have difficulty seeing the benefits of a paid leave system as clearly as the costs.

RELATED CONSIDERATIONS

1. Professional Accountability
   a) The professionals should bear some responsibility for the costs of maintaining their professional skills. This is in place now to an extent through professional fees, a portion of which are used for continuing education purposes.
   b) The professional should pay continuing education tuition fees and possibly some travel costs.

2. Implementation Suggestions
   a) The needs of remote health professionals would be better served by changing delivery systems for continuing education so that learning opportunities were available in or near their communities. It would be more efficient to make funds available to continuing education providers for this purpose than to pay travel costs for health professionals.
   b) Educational leave should be linked to the results of performance appraisals, where appropriate.
   c) The concept of "sabbatical leave" as it is understood in educational institutions should apply to health professionals to allow for extended study, clinical traineeships, etc.
   d) The language of existing contracts should be refined and clarified and relevant provisions enforced so the educational leave provisions are equally available to all those covered by the contract.

3. Dietary Support Personnel
   a) It is important educational leave opportunities be available not only to Dietitians and Nutritionists but also to dietary support personnel.
   b) Apprenticeship programs are seen as a vital educational need for some categories of dietary support personnel.

4. Professional Standards
   In order to make effective use of a system of paid educational leave, the BCDNA feels a clearly defined set of professional standards must be in place and effective procedures for monitoring performace against those standards. The results could be integrated with the planning of continuing education programs and activities. Although such a system seems to be necessary to justify investments made in paid leave, the BCDNA, a voluntary association staffed largely by volunteer personnel, would need resources to support full-time personnel (possibly an Executive Director and an educator) who would develop and maintain the system.

MEDICINE

DEFINITION

1. A Physician in General Practice:

"Diagnoses and treats diseases, disorders and injuries of the human body. Questions and examines patient. Orders and performs laboratory tests, X-rays and other diagnostic procedures. Analyzes reports and findings of tests, X-rays and examination to diagnose condition. Prescribes and administers treatments and drugs. Prescribes physiotherapy and other remedial treatments. Inoculates and vaccinates patient to prevent communicable diseases. Advises patients to follow good diet, exercise and other health habits to aid in prevention of disease and disorders. Provides pre- and post-natal care, and delivers babies. Reports births, deaths and contagious diseases to governmental authorities. Refers patient to specialists, and assists in surgical procedures. Conducts insurance and preemployment physical examinations. Performs surgery, if required.[1]

This submission is intended to apply in a general way to all physicians and surgeons including those in specialty and sub-specialty practice as well as general practitioners. None of those interviewed was selected because of his/her role in a particular field of medical practice, but rather because of his/her knowledge of continuing education and its relationship to possible paid educational leave.

APPROXIMATE NUMBERS

In September 1982, there were 5861 physicians registered with the College of Physicians and Surgeons of British Columbia.[2]

TYPES OF PRACTICE [3]

Fee for Service ("Private Practice")	90%
- Solo or group practice	
Salaried physicians	10%
- University faculty	
- Government	
- Licensing Bodies, Associations	
- Workers' Compensation Board	
- Agencies	
	100%

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[1] Canadian Classification and Dictionary of Occupations 1980. Major Group 31, No. 3111-166, p.49, Ottawa: Employment and Immigration Canada. (For definitions of medical specialists see pages 45-49 of the same publication).

[2] ROLLCALL UPDATE 82, p. 6-7

[3] Percentage figures are gross estimates only, provided by interviewees.

SPECIALTIES

Categories of physicians listed in ROLLCALL UPDATE 82 include:

1. General Practice (including physicians with certfication in "Family Medicine".

2. Clinical Specialities
   - Anaesthesia
   - Cardiology
   - Clinical Immunology
   - Community Medicine
   - Dermatology
   - Diagnostic Radiology
   - Gastroenterology
   - Haematology
   - Internal Medicine
   - Neurology
   - Neuropsychiatry
   - Nuclear Medicine
   - Paediatrics
   - Paediatric Cardiology
   - Physical Medicine and Rehabilitation
   - Psychiatry
   - Public Health & Community Medicine
   - Radiation Oncology
   - Respiratory Medicine
   - Rheumatology

3. Laboratory Medicine Specialities
   - Anatomical Pathology
   - Bacteriology
   - General Pathology
   - Haematological Pathology
   - Medical Biochemistry
   - Medical Microbiology
   - Neuropathology
   - Pathology

4. Surgical Specialities
   - General Surgery
   - Neurosurgery
   - Obstetrics and Gynaecology
   - Ophthalmology
   - Otolaryngology
   - Orthopaedic Surgery
   - Paediatric General Surgery
   - Plastic Surgery
   - Thoracic & Cardiovascular Surgery
   - Urology

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[1] ROLLCALL UPDATE 1982, p.p. 6-2 to 6-4.

FORMS OF CONTINUING EDUCATION

1. Formal
   a) Hospital rounds (1 - 2 hours)
   b) Refresher courses (1 - 5 days)
   c) Traineeships (full time, 1 week - 6 months)
   d) Televised series via satellite
   e) Lecture series
   f) Medical meetings and conferences.

2. Informal
   a) Physicians to physican consultations
   b) Reading journals and texts
   c) Audiotapes
   d) Videotapes.

MANDATORY CONTINUING EDUCATION

1. In order to practice as a physician in British Columbia it is necessary to be licensed by the College of Physicians and Surgeons of British Columbia.

2. Continuing education is not a requirement for licensure in British Columbia.

3. The Canadian College of Family Physicians has a mandatory continuing education requirement for membership. However, membership is voluntary. General practitioners can practice without being members.

4. Some B.C. Physicians belong to American speciality societies which have mandatory continuing education requirements. Membership is voluntary because they can continue to practice the specialty in British Columbia without membership in the American society.

ROLES OF CONTINUING EDUCATION

1. Maintaining basic competence.

2. Acquiring new knowledge and skills.

3. Facilitating role changes.

4. Professional advancement.

ABILITY OF CONTINUING EDUCATION TO FULFILL ROLES

There were some differences of opinion among those interviewed about whether continuing education as it currently exists is adequately fulfilling the roles outlined above. Points raised included:

1. There is no way to determine at present whether continuing education improves practice and therefore whether roles are fulfilled.

2. There is no way to evaluate whether those in need of improvement are participating and/or whether those who participate need what is provided.

3. Adequate continuing education opportunities exist in North America to enable British Columbia physicians to fulfill the roles.

AVAILABILITY OF PAID EDUCATIONAL LEAVE

Some form of paid educational leave or financial assistance for continuing education purposes is available to most British Columbia physicians.

1. British Columbia Medical Education Fund
This Fund, unique in Canada, provides reimbursement for expenses already incurred for participation in educational experiences relevant to the applicant's practice. The Fund was established in April 1974 in lieu of part of a fee increase that year. General particulars are:
   a) To apply for monies from the Fund, a physician must have practised in B.C. for at least 12 months, and have been paid on a fee for service and/or sessional basis by the Medical Services Plan of B.C.
   b) Up to $620.00 per year is available to each eligible doctor. Funds may be allowed to accumulate for a maximum of 3 years.
   c) The funds may be used for attending educational meetings or courses, and with certain specific limits, for the purchase of books, journals, tapes and/or audiovisual equipment. Maintenance (room and board), travel, and office overhead are provided for with specific limits for each.
   d) All applications are scrutinized and must be accompanied by appropriate documentation.
   e) Monies obtained from the fund are subject to income tax. Expenses can be deducted.

2. Salaried Physicians Employed by the Provincial Government
Specific educational leave arrangements are provide for salaried physicians employed directly by the Provincial Government. They include:
   a) Leave with full pay and normal benefits for seven years of service. Requests for such leave are "considered by the Deputy Minister." Employees granted such leave may be required to sign a return service agreement.
   b) Leave without pay with return service or repayment provisions.
   c) Leave with pay and expenses up to five days per annum to attend professional conferences, seminars, workshops, etc. This leave is discretionary but approval is not to be unduly withheld, provided the needs of the service are satisfied.
   d) Reimbursement of costs for personal material up to a maximum of $250.00 per annum (not to include costs related to attending organized training sessions). Materials include pre-recorded instructional cassette tapes, portable and automobile cassette players, text books, professional journals and magazines.

3. Salaried Physicians Employed by Agencies.
The Provincial Government salary scales are used by the Medical Services Plan to reimburse agencies who employ physicians for clinical services. The agency is generally paid 1 1/2 times the listed salary. The extra 50 percent goes toward overhead costs and fringe benefits which may include paid educational leave. In 1981-1982, the Medical Services Plan reimbursed agencies for 423 full or part-time salaried physicians.

4. Salaried Physicians Employed by the Workers' Compensation Board (WCB).
   a) Leaves of absence without pay may be granted for relevant educational training to a maximum of one year for seven years of service.
   b) Leaves of absence with pay up to six weeks may be granted for participation in courses where the connection between the course and WCB operations is positive and direct.
   c) Leaves with pay and expenses up to five days per annum may be granted to attend professional conferences, seminars, workshops, etc. (This is currently under negotiation to make it mandatory).

5. Salaried Physicians Employed by Educational Institutions.
Provisions vary among different institutions. They may include:
   a) Sabbatical or Study Leaves of one year with full or part salary for research or study. Such leaves are subject to certain conditions having been met. e.g. length of service, length of time since previous leave, academic rank.
   b) Leave without pay for improving qualifications.
   c) Leaves of shorter duration may be negotiated with the employer. Terms vary with respect to salary continuance and reimbursement of expenses.

RELATIONSHIP OF CONTINUING EDUCATION TO PAID EDUCATIONAL LEAVE

DESIRABILITY OF PAID LEAVE

There was unanimous agreement among those interviewed that a system of paid educational leave was desirable although some concerns were expressed.

PERCEIVED BENEFITS

1. Maintained Professional Competence.
Medicine is a dynamic profession. Some estimate that 65% of knowledge and skills acquired in undergraduate training is lost or becomes obsolete in the first 5 years of practice. Therefore, participation in continuing education is essential to maintain competence. Lack of participation does not produce a static condition. Erosion of competence occurs which accelerates the obsolescence caused by the rapid pace of growth of scientific knowledge in medical field. Paid educational leave would stimulate participation in continuing education and consequently help to ensure competence is maintained.

2. Improved Patient Care.
Paid educational leave should increase participation in continuing education both by those who participate at present and those who do not. This, in turn, should improve the quality of patient care.

3. Stimulus to Continued Learning.
   Paid educational leave would facilitate physicans' access to academic environments. Being in the academic environment is a necessary stimulus to physicians who are able learners, but who require the necessary conditions to facilitate learning.

PERCEIVED PROBLEMS OR CONCERNS

1. Economic and Financial Factors.
   The potential cost to the health care system appears to be potentially enormous.

2. Replacement Personnel.
   Availability of personnel to replace physicians in smaller and/or remote communities would be a problem. The level of care in their absence could be a serious concern.

3. Continuing Education Providers.
   a) Systems would have to be expanded and re-structured.
   b) Extensive and varied programs would have to be provided: topics, times, locations, delivery modes.

4. Administration of the System.
   a) Guidelines would have to be formulated and monitored: How much time? At what intervals? For what purposes? What types and levels of "payment?"
   b) In whose hands would responsibility for administering the system lie: professional bodies? government?

5. Productivity.
   The system would have to be defensible from the point of view of productivity. Research would be required to determine the most productive kinds, amounts, etc. of leave.

6. Mandatory Continuing Education by Default?
   If universal paid educational leave were made available, would participation in continuing education become mandatory as a result? If an individual chose not to participate, would his competence be questioned? If so, how and by whom would his competency be assesed?

RELATED CONSIDERATIONS

1. Professional Accountability.
   Agreed physicians should bear a portion of the cost of their continuing education professional education.

2. Research Requirements.
   a) Before or as such a system is instituted, careful attention should be paid to:
      - Relationships between participation in continuing education and improvements in the quality of care.
      - Analysis of participation to ensure those who need improvement are participating in continuing education.

- Analysis of learning needs (competence?) to ensure continuing education being provided is congruent with needs.

b) Paid educational leave appears to be a worthwhile idea but the enormous potential expense makes it imperative a cost-benefit analysis be conducted to determine whether it is cost-effective.

3. Implementation Suggestions.
The British Columbia Medical Education Fund presents a possible system to obtain and administer funds for professionals working on a "fee for service" basis.

NURSING

DEFINITION

"The Registered Nurse chooses to function in any one of the identified roles and performs the functions within his/her chosen role according to academic preparation, experience, established policies of the employing agency, and the terms of contracts in existence in the area of practice.
The Registered Nurse functions in a very wide variety of settings, acute, extended, intermediate and personal care; public health, home care, mental health, doctors' offices; colleges and universities. Choice of roles can be that of Practitioner, Educator, Administrator and Researcher."[1]

APPROXIMATE NUMBERS

In June 1982, there were a total of 25,726 practicing and non-practicing Registered Nurses in British Columbia.[2]

TYPES OF PRACTICE [3]

1.	General Staff Nurses	85.5%
	Administration	11.0%
	Teaching Roles	3.5%
		100.0%
2.	Specialized Practice	43%
	Non-Specialized Practice	57%
		100%

FORMS OF CONTINUING EDUCATION

1. Forms
   a) In-Service Education
   b) Short Courses and Conferences (1 - 5 days)
   c) Post Basic Programs (6 weeks FTE to 1 year FTE)

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[1] Guide to the Definition of the Roles and Functions of the Licensed Practical Nurse, the Registered Nurses and the Registered Psychiatric Nurse. Joint Statment of, The Licensed Practical Nurses' Association of British Columbia, The Registered Nurses' Association of British Columbia and The Registered Psychiatric Nurses' Association of British Columbia, Febrary 1977, p.9.

[2] ROLLCALL UPDATE 82, p. 7-6 (see References).

[3] percentage figures are gross estimates only, provided by interviewees.

2. Formats
   a) Guided Independant Study
   b) Classroom Study
      - in major centres
      - in smaller centres
   c) Guided Clinical Study
      - in agencies
      - simulations.

MANDATORY CONTINUING EDUCATION

1. In order to practice as a Registered Nurse in British Columbia, it is necessary to be registered by the Registered Nurses Association of B.C.

2. Continuing Education is not a requirement for registration at the present time.

ROLES OF CONTINUING EDUCATION

1. Maintaining basic competence.

2. Acquiring new knowledge and skills.
   e.g. Changes in work setting created by new developments and/or added responsibility.

3. Facilitating role changes.
   e.g. Medical-surgical nurses taking post basic courses to become specialists in critical care.

4. Professional advancement.
   e.g. Post basic program certificates permit graduates to apply for advancement in terms of role and/or salary.

5. Re-entry to profession.

6. Continued development and reinforcement of professional values.
   e.g. Viewing nursing as a career and not just a job. Establishing and reinforcing commitment to lifelong learning.

ABILITY OF CONTINUING EDUCATION TO FULFILL ROLES

It was agreed continuing education as it is presently available is unable to fulfill the roles outlined above. Some reasons are:

1. Work Factors.
   Nurses work in shifts that cover a 24 hour day. Continuing education programs are frequently offered at times not convenient to shift work, particularly when nurses also have family responsibilities.

2. Programming Factors.
   a) Distance from educational centres. Many nurses are required to travel significant distances, losing time and creating travel costs.

b) Relevance and timeliness of programs is a problem. When the need for a skill or some particular knowledge occurs, an educational program is usually not available to respond to the need at that time.

3. Role Factors.
Most nurses are women. Continuing education must compete with family responsibilities for free time.

4. Informational Barriers.
   a) Insufficient advance notice is often given. Nurses' schedules are set up to two months in advance. Time is required to make arrangements for replacement, rescheduling, etc.
   b) Inadequate publicity. Nurses don't have the skills to judge the relevance of programs from information in brochures.

5. Attitudinal/Motivational Factors.
   a) Some feel they have learned all they need to know in basic programs.
   b) Some may have had unpleasant educational experiences in the past and may be reluctant to participate.

6. Cost Factors.
   a) Continuing education costs must compete with family costs for discretionary dollars. Nurses tend to spend on families rather than on themselves, and therefore personal funds available for continuing education are limited.
   b) Where programs exist, agencies don't have sufficient funds to cover replacement salaries and tuition. Individuals cannot afford to bear all costs.
   c) If providers can obtain the necessary funds for the development of new programs, they cannot be certain enrollment will be high enough to generate sufficient revenue to cover implementation costs.
   d) Re-entry is difficult because of the necessary length of programs and associated costs to learner.

AVAILABILITY OF PAID EDUCATIONAL LEAVE

1. Provisions for Leave.
   a) Most nurses employed in hospitals in British Columbia are covered by the Collective Agreement between the Health Labour Relations Association of B.C. and the RNABC Labour Relations Division. Some provisions are included for leave of absence with pay both for attending education programs and for professional meetings.
   b) A similar agreement exists for public service employees.
   c) Faculty at educational institutions have access to periodic sabbatical or study leaves at intervals of several years and to annual leaves with varying terms and conditions, depending on the institution.
   d) The view was expressed that existing provisions for short term leave seem adequate, if they are enforced, but that longer term leaves must be provided for those entering a new speciality area or undertaking teaching or administrative roles.

2. Access to Leave.
   a) It was agreed even though the majority of B.C. Nurses are covered by contracts that include provisions for educational leave, such leaves are not universally available to members of the unions concerned. The wording of the contracts is being interpreted in such a manner as to place the granting of leaves at the discretion of the employer.
   b) Nurses not under contract must negotiate leaves on an individual basis. The perception was expressed that some employers are encouraging the creating of special categories of nurses and as a result are removing eheir obligation to honor the provisions of contracts relating to leave for those nurses, since the contract would not apply to the newly defined roles.
   c) The availability of leaves for all nurses is drastically curtailed during the current economic recession.

RELATIONSHIP OF CONTINUING EDUCATION TO PAID EDUCATIONAL LEAVE

DESIRABILITY OF PAID LEAVE

It was agreed by those interviewed that universal paid educational leave for Registered Nurses is desirable. In fact, the view was expressed that paid leave for continuing education is essential. The following reasons were cited:

1. No training is provided in basic programs for nurses in specialized practices, administration, or teaching roles.

2. If part of a person's job is maintaining and updating skills, it is unreasonable to expect them to do this job without pay.

3. Businesses allocate a specified portion of budget to maintain physical plant and machinery. Maintenance of personnel resources is not budgetted in a similar manner. Morever, education budgets are the first to be cut. This seems unreasonable, given the large portion of health care budgets devoted to personnel.

4. Financial considerations have limited participation by nurses in continuing education, although they are eager to participate. Paid leave would encourage non-attenders to participate, and would encourage attenders to participate more effectively. Active participatns tend to act as motivators and change agents in the practice setting.

PERCEIVED BENEFITS

1. Universal paid educational leave would enable continuing education to fulfill its stated roles more effectively, resulting in better health care.

2. Optimum utilization of existing nurses who are not working to full potential.

3. Increased job satisfaction resulting in benefits both to the employee and to the employer (e.g. decrease in job turnover).

4. Making life long learning a reality rather than paying lip service to it.

PERCEIVED PROBLEMS OR CONCERNS

1. Economic and Financial.
   a) The possiblity of significant costs, particularly associated with replacement salaries was mentioned as a potentially serious problem.
   b) The view was expressed that there was an appearance of added costs and benefits would actually offset any such costs. For example, lower turnover of staff would reduce recruiting, orientation and training costs. It was pointed out this is the actual experience of one B.C. hospital which has maintained its policy of granting leaves in spite of the recession.

2. Continuing Education Providers.
   a) Funding, personnel and physical resources would have to be provided to cope with the increased demand that a paid leave system would create.
   b) Personnel would have to be prepared to develop and teach programs.
   c) Facilities not available for continuing education purposes in educational institutions at present would have to be made available.
   d) A system of evaluation would have to be put in place to evaluate outcomes at the various stages of the process: learning, competence, performance.
   e) A system would have to be created to ensure programs of consistently high quality were being offered by all providers and duplication was avoided.
   f) A system would have to be established to obtain informed consumer input into program development.

3. Abuses.
   Abuses of a paid leave system were cited as a potential problem but it was felt they could be countered by having nurses bear a portion of the costs.

RELATED CONSIDERATIONS

1. Professional Accountability.
   a) It was agreed individual nurses should bear a portion of the costs of continuing professional education.
   b) It was suggested where attendance is required by the employer, all costs should be borne by the employer.
   c) Where participation is discretionary, it was suggested a reasonable cost-sharing might have nurses carrying one-third of the cost.

2. Health Manpower Planning.
   The view was expressed that health manpower planning groups should be encouraged to provide more precise data with regard to demand for refresher programs and for skills training in specialized areas. Communication links should be established with continuing education providers so current data can be used to predict educational needs and to develop timely programs.

PHARMACY

DEFINITION

"The pharmacist is responsible for the storage and distribution of prescription and non-prescription medications as well as provision of information on their appropriate storage and use by the patient."[1]

APPROXIMATE NUMBERS

In September 1982, 1985 Pharmacists were registered with the College of Pharmacists of British Columbia.

TYPES OF PRACTICE [2]

Community (Retail) Pharmacy	85%
Hospital Pharmacy	10%
Other	5%
	100%

There are approximately 580 community pharmacies and 70 hospital pharmacies in British Columbia.

FORMS OF CONTINUING EDUCATION

1. Short courses, seminars and workshops (1 to 2 1/2 days in length)
2. Evening lecture series
3. Correspondence courses (print materials)
   - University of British Columbia courses
   - Other provinces and states
   - Pharmaceutical companies
   - Pharmaceutical journals
4. Television programs transmitted via satellite
5. Audioconferences (telephone)
6. Audiotape lending systems
7. Videotape lending systems.

MANDATORY CONTINUING EDUCATION

1. In order to practice as a pharmacist in British Columbia, it is necessary to be registered by the College of Pharmacists of British Columbia.

2. Continuing education is not mandatory for pharmacists in British Columbia on a universal basis. However, the College of Pharmacists has a "Competency Assessment Project." Specific continuing education programs are mandated for pharmacists who do not perform well on written tests.

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[1] The College of Pharmacists of British Columbia.

[2] Percentage figures are gross estimates only, provided by interviewees.

3. Three provinces (Man., Alta., Sask.) and 25 states have mandatory continuing education requirements that must be met by pharmacists practicing in B.C. who want to maintain their licences in those jurisdictions.

ROLES OF CONTINUING EDUCATION

1. Maintaining basic competence.

2. Acquiring new knowledge and skills.

3. Facilitating role changes.
   e.g. 1) Profession is shifting from product-oriented to a process-oriented type of practice. Pharmacists are acting as patient counsellors and as drug information resources. Continuing education is helping to facilitate this transition.
   2) Training community pharmacists to work as hospital pharmacists. The hospital pharmacist acts as a drug information resource much more than community pharmacists and therefore requires more detailed and specialized knowledge. (e.g. Total Parenteral Nutrition).

4. Professional advancement.

5. Socialization: informal learning occurs and professional relationships strengthen.

ABILITY OF CONTINUING EDUCATION TO FULFILL ROLES

There was some differences of opinion among those interviewed about whether continuing education as it currently exists is adequately fulfilling the roles outlined above. Points raised were:

1. There are approximately 2000 pharmacists in B.C. Each is at a different level than the others. UBC, which is the major provider, cannot provide sufficient learning opportunities of a kind, in a place, and at a time that would meet the multiplicity of learning needs.

2. At present, continuing education is just skimming the surface. The ability of the profession to bring about transition from product-orientation to process-orientation is limited by economic factors. Time spent in counselling is not remunerated, only dispensing is remunerated. Therefore, continuing education programs related to this role change are not popular.

3. Adequate continuing education opportunities exist to enable it to fulfill the roles mentioned because of the variety of types of programs and delivery systems including a network of Regional Co-ordinators who plan and implement programs in or near most communities.

AVAILABILITY OF PAID EDUCATIONAL LEAVE

1. Provisions for Leave
   a) The British Columbia Pharmacists' Society Employment Code contains provisions for educational leave. These provisions act as a guideline for negotiations between employers and employees.
   b) Some pharmacists are members of unions whose contracts include provision for paid educational leave.
      e.g. Health Sciences Association (Hospital Pharmacists)
      Retail Clerks Union Local 1518 (some community pharmacists)
      B.C. Government Employees Union.

2. Access to Leave
   It was agreed paid educational leave is not universally available to all B.C. pharmacists. Access to leave appears to be determined largely on the basis of individual negotiations. During the current economic recession, educational leave is seen as minimally available.

RELATIONSHIP OF CONTINUING EDUCATION TO PAID EDUCATIONAL LEAVE

DESIRABILITY OF PAID LEAVE

It was agreed by those interviewed that universal paid educational leave for B.C. pharmacists was a desirable goal, but certain reservations were also expressed.

PERCEIVED BENEFITS

1. Improved Quality of Care.
   Paid educational leave would enable continuing education to fulfill its stated roles more effectively, and as a consequence the over-all quality of service to the public would be improved.

2. Increased Participation in Continuing Education.
   A major barrier to participation in continuing education is the costs involved. An individual pharmacist has a limited number of dollars to invest in continuing education. Loss of salary plus travel and tuition costs curtails participation significantly. Removing the cost barrier should increase participation.

PERCEIVED PROBLEMS OR CONCERNS

1. Economic and Financial.
   The costs to employers and the economy appear to be enormous.

2. Continuing Education Providers.
   a) In addition to funds to free individuals for educational leave, resources would have to be made available to ensure the availability of a sufficient number of high quality programs. Staff, facilities and other educational resources presently available could not cope with the sudden dramatic increase in demand that a paid educational leave system might be expected to create.

b) The educational system would be obligated to ensure all programs were of a high quality to warrant the investment being made in paid leave.
   i) Needs identification would have to focus on real, educational needs and not rely on pharmacists' perceptions of needs.
   ii) The educational design and calibre of instruction would be expected to be of high quality.
   iii) Sound evaluation of outcomes at all stages of the process would be expected.

3. Replacement Personnel.
The availability of replacement personnel is a concern, particularly for those working in "one-man" pharmacies (5% to 10% of the 580 community pharmacies).

RELATED CONSIDERATIONS

1. Professional Accountability.
   a) It was agreed individual pharmacists should be expected to bear some of the costs of continuing professional education.
   b) One person interviewed suggested the individual pharmacist should be responsible for costs associated with maintaining basic competence. Costs of other continuing professional education should be borne by the employer because benefits would flow to the employers as a result of improved performace.

2. Access.
Equal access to the benefits of any system of paid leave must be provided to all pharmacists regardless of their geographic area or type of practice.

3. Implementation Suggestions.
   a) Where prescriptions are paid through a third party, a few cents per prescription could be withheld for continuing education purposes. The resulting education fund should be administered by the College of Pharmacists.
   b) The College of Pharmacists is impowered to raise membership fees to produce funds specifically for continuing education purposes.
   c) Disproportionate costs presently being borne by pharmacists in remote t and small communites (for travel and accomodation) could be equalized by a funding and tuition free formula that took all such costs into account and distributed them equally among all participants.
   d) If a system of universal paid educational leave is not possible, tax concessions should be considered for employee professionals of a similar nature to those presently available to self-employed and employer professionals. However, the implications of such a move for other categories of employees is noted.

REHABILITATION MEDICINE

For the purposes of this submission, two professions are included in the broader professional category of Rehabilitation Medicine: Occupational Therapists and Physiotherapists.

DEFINITIONS

1. A Physiotherapist:

"Plans and carries out program of physical treatment, in consultation with physician and other health care workers, to rehabilitate injured or disabled patients.
Administers muscle, nerve, joint and functional ability tests to identify, physical problems of patient. Assesses patients' symptoms and capabilities. Directs and aids patients individually or in groups, in exercises designed to assist in muscle restoration and joint mobility. Guides patient in remedial activities involving use of parallel bars, weights, traction and other equipment. Gives whirlpool and contrast baths and applies moist packs. Administers treatments, using diathermy, ultrasonic and microwave machines, infra-red and ultra-violet lamps, low voltage generators and other electro-therapeutic equipment. Instructs patients and their families in procedures to be continued at home. Records treatments given and patients' responses and progress."[1]

2. An Occupational Therapist:

"Plans and carries out treatment programs based on activities such as work, education and recreation to rehabilitate physically and mentally disabled persons.
Administers tests and observes patient to assess emotional, mental and physical capacities of patient. Plans and directs programs in manual and creative arts, industrial and vocational skills, recreational activities, remedial games, cultural and educational interests, and play activities for children. Conducts group programs to assist patients in building self-confidence and in adjusting to family and community. Trains handicapped patients in self-care and daily living activities. Advises and instructs patients on specially-adapted household equipment and furnishings. Assesses patients' vocational potential and provides work adjustment and actual work experience. Participates in testing and training of patients with perceptual motor problems, and provides training for children, with learning disabilities. Records patients' activities, response and progress. Attends meetings of rehabilitation team."[1]

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[1] Canadian Classification and Dictionary of Occupations 1980. Major Group 31, No. 3137-122, p.56, Ottawa: Employment and Immigration Canada.

APPROXIMATE NUMBERS

In October 1981, 302 Occupational Therapists were members of the B.C. Society of Occupational Therapists, and 1142 Physiotherapists were registered members of the Association of Physiotherapists and Massage Practitioners of B.C.[1]

TYPES OF PRACTICE [2]

1. Occupational Therapists

Hospitals and Speciality Institutions	98%
Mental Health, Home Care, Other	2%
	100%

2. Physiotherapists

Institutions	65%
Private Practice	15-20%
Community Care	10-15%
Consultants	2%
	100%

FORMS OF CONTINUING EDUCATION

1. Short courses and workshops (1 - 3 days)

2. Courses associated with conferences

3. Sequential series of short courses (1 day or part days) leading to incremental qualifications

4. Intensive short courses (up to 8 weeks) in a speciality area.

MANDATORY CONTINUING EDUCATION

1. Occupational Therapists.
   a) Compulsory registration and licensure does not exist.
   b) Membership in the British Columbia Society of Occupational Therapists is voluntary.
   c) Mandatory continuing education for Occupational Therapists does not exist in British Columbia at the present time, but is being considered by the profession.

2. Physiotherapists.
   a) In order to practice as a Physiotherapist in British Columbia, it is necessary to be registered by the Association of Physiotherapists and Massage Practitioners of British Columbia as either a "Chartered" or "Registered" member.

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[1] ROLLCALL 81, p.p. 17-5 and 22-5

[2] Percentage figures are gross estimates only, provided by interviewees.

b) Mandatory continuing education does not exist for Physiotherapists in British Columbia at the present time.

ROLES OF CONTINUING EDUCATION

1. Maintaining basic competence.

2. Acquiring new knowledge and skills.

3. Facilitating role changes.
   e.g. Occupational Therapy: The profession as a whole is establishing a clearer definition of its role. This process is being facilitated by continuing education.
   e.g. Physiotherapy: In-patient to out-patient setting: orthopaedics to intensive care; clinical role to administration or teaching.

4. Professional advancement.
   e.g. Occupational Therapy: Sub-speciality courses are required for advancement to positions of greater responsibility.
   e.g. Physiotherapy: Certain types of courses may place Physiotherapists in a preferred position for advancement, but such courses cannot be required by prospective employers.

5. Re-entry to the professions.

ABILITY OF CONTINUING EDUCATION TO FULFILL ROLES

There was some difference of opinion among those interviewed about whether continuing education as it currently exists is adequately fulfilling the roles outlined above. Points raised were:

1. Considering the various types of continuing education available, the roles are being fulfilled on an over-all basis.

2. Geographic access is a problem both within B.C. and across Canada, particularly in specialty areas.

3. Specific needs are not being met.
   e.g. University-level courses which require extensive participation over prolonged periods of time.

4. People wishing to re-inter work force don't have convenient and cost-effective access to the necessary programs.

5. There is a shortage of expert resource people to teach continuing education programs. Networks of such speakers appear to exist in the United States, but not in Canada.

AVAILABILITY OF PAID EDUCATIONAL LEAVE

1. Members of both professions who belong to unions have access to the provisions of contracts providing for paid leave. For example, the Health

Sciences Association agreement which covers both groups provides up to a maximum of four (4) days of leave per year, subject to the approval of the employer.

2. For others, access to paid leave varies and must be negotiated with the employer.

3. During the current economic recession, paid leave has been drastically curtailed for members of both professions.

RELATIONSHIP OF CONTINUING EDUCATION TO PAID EDUCATIONAL LEAVE

DESIRABILITY OF PAID LEAVE

It was agreed by those interviewed that universal paid educational leave should be available to Occupational Therapists and Physiotherapists.

Reasons given included:

1. It is impossible to keep abreast of knowledge explosion. People's skills may become obsolete without their even realizing it. A uniform, systematic means of "access" to continuing education opportunities is essential to ensure than an acceptable standard of health care is maintained.

2. Continuing education programs at present tend to be mainly short courses and workshops. They provide an overview and introduction but cannot provide the level of knowledge and skills required for specialized practice. Specialized programs tend to be of longer duration and require a paid leave arrangement to make participation possible.

PERCEIVED BENEFITS

1. Improved Quality of Care.
   A universal system of continuing education would facilitate access to programs. This in turn would lead to over-all improvement in the standard of care and would help remedy deficiencies in care that may exist in smaller communities.

2. Job stability.
   People tend to be mobile among practice areas. Paid leave might encourage people to develop a higher level of skills in the specialty area in which they practice. Master clinicans might result resulting in a higher quality of service and in less staff turnover.

3. Improved Research Potential.
   Continuing education activities tend to foster an interest in research, both in health care and in education.

PERCEIVED PROBLEMS OR CONCERNS

1. Quality of Educational Programs.
   Paid leave would increase demand and might cause the quality of continuing

education programs to deteriorate unless resources were provided to continuing education providers. Providing payment for leaves would necessitate ensuring continuing education programs were of uniformly high quality directly related to the learning needs of participants.

2. Economic and Financial.
The costs of such a system could be enormous because a number of types and levels of funding would be required.
   a) To develop standards of care or levels of stated competence.
   b) To develop the continuing education programs required to enable the professionals to meet the standards.
   c) To evaluate program quality.
   d) To enable professionals to participate.
   e) To assess the competence of the individuals and the quality of care.

3. Replacement Personnel.
Funding would have to be made available for replacement personnel. This is particularly important in smaller communities where there is no staff to "cover" for those on leave.

4. Implementation Concerns.
   a) A system would have to be put in place to assess the relevance of the educational programs for which leave were being granted and the suitability of the applicant.
   b) To ensure effective outcomes, attendees should be required to share the results of the program they attend or otherwise demonstrate their usefulness.

5. Abuses of the System.
Individuals granted leave might not attend or if they attend, might not participate in a meaningful way.

RELATED CONSIDERATIONS

1. Professional Accountability.
Agreed professionals should regard continuing education as a part of their professional responsiblity and they should bear a portion of the cost.

2. Mandatory Continuing Education.
Occupational Therapists are considering mandatory continuing education. A system of paid educational leave is seen as an important complement.

SIGNIFICANT OTHERS

THOSE INCLUDED

This section represents the perceptions, suggestions and recommendations of individuals who are prominent in the health care field in British Columbia and who now are or have recently been in major roles relating to continuing education in the health sciences for a broad range of health professionals.

DEFINITION OF CONTINUING EDUCATION

There were differences of opinion among members of this group about the proper meaning of the term "continuing education." Some felt it should be limited to short-term activities of a non-credit nature. Others felt most types of formal educational activities should be considered, including refresher, re-entry and professional "upgrading" programs, some of which could involve credit toward advanced degrees. It was agreed full-time study in degree programs, and post-graduate clinical programs leading to recognized, licensed specialty qualifications should not be included.

ROLES OF CONTINUING EDUCATION

1. Maintaining basic competence.

2. Acquiring new knowledge and skills.

3. Facilitating role changes.

4. Professional advancement.

5. To contribute to the field of knowledge about how adults learn through research and publication.

6. Intellectual stimulation leading to seeking further opportunities for learning and creative approaches to apply new learning in the practice setting.

7. Increased job satisfaction in knowing one is current and up to date.

8. Collaboration with colleagues resulting in shared solutions to common problems and building and strengthening professional support systems.

9. Re-entry to active practice for those who have been out of practice for a period.

ABILITY OF CONTINUING EDUCATION TO FULFILL ROLES

Continuing education is addressing all roles in part but is not adequately fulfilling every role in all professions. Reasons cited included:

1. Participation Factors.
   a) Not everyone chooses to participate in continuing education. For those who choose to participate, it may be successful in maintaining basic competence and to a limited degree enabling them to acquire new knowledge and skills.
   b) Some professionals have no intention to participate at all. Therefore, even their basic competency is eroding.

2. Access Factors.
   Many health professionals do not have access to continuing education opportunities because of geographic remoteness, professional responsibilites (demanding schedules, shift work), family responsibilities, etc.

3. Program Formats.
   Continuing education does not deal adequately with the longer-term programs needed for refresher or re-entry.

4. Promotion Factors.
   Many health professionals are inadequately informed about continuing education opportunities available because no comprehensive, systematic means of distributing information exists.

RELATIONSHIP OF CONTINUING EDUCATION TO PAID EDUCATIONAL LEAVE

DESIRABILITY OF PAID LEAVE

It was unanimously agreed paid educational leave for continuing education is desirable. There was no unanimity on its advisability. Most of those interviewed felt the potential benefits outweighed the disadvantages. One was so seriously concerned about the economic implications as to be unable to recommend the question of paid leave be pursued.

PERCEIVED BENEFITS

1. Quality of Health Care.
   a) Canadian geography places profesionals in isolated situations that may mean a lower level of health care is provided in the communities which they serve. This is not consistent with current thinking by virtue of which all people should have access to the same level and quality of services. A system of paid educational leave would help considerably in enabling continuing education to maintain and enhance the competence of all health professionals, thereby ensuring a uniform high level of care in all areas.
   b) A system of paid educational leave would likely result in more frequent attendance by those presently attending continuing education programs and would encourage attendance by those not attending. Improved participation should help to improve the over-all quality of health care.

2. Access.
   a) Rapid changes are occurring in all health professions. Dissemination of new knowledge as quickly as possible to all those who need to

receive it is a critical problem. Uniform, rapid and systematic access could be facilitated through a program of paid educational leave.

b) Paid educational leave might encourage people to relocate at intervals for longer-term intensive programs. Access to such programs is severely restricted at present.

3. Employment "Benefits".
Investment in the form of paid educational leave would be recognized by the recipients, leading to increased job satisfaction, willingness to accept and initiate change, improved employer-employee relations, less staff turnover, etc.

4. Educational Considerations.
   a) A system of paid educational leave could foster the growth of an attitude among health professionals that life-long learning is an integral part of a professional career. This could lead to an unprecedented acceleration in the demand for continuing education programs and in related research activities.
   b) Support from government and employers, and increased interest among health professionals could create a stable funding base and a predictable demand for continuing education programs that would allow for long-range planning by educational providers, greater diversity of programs and new systems of delivery.

PERCEIVED PROBLEMS

1. Economic and Financial.
   a) The potential costs of a universal system of paid leave are perceived as being significant, possibly significant enough to make such a system unfeasible. This is exemplified by recent developments in Radiology: Digital Radiography, Nuclear Magnetic Resonance, and Cat Scanning. Extensive retraining is required. Paid leave would be enormously expensive because of the high salaries involved and the need to pay two salaries during the training period (one for a replacement).
   b) Resistance to a system of paid leave could be generated by the taxpayers who might have difficulty seeing the benefits as clearly as the costs.

2. Replacement Personnel.
Absences for education might not be feasible in all cases, particularly for health professionals in smaller or isolated communities where replacement personnel might not be available.

3. Quality of Health Care.
The quality of care could suffer in the short term, particularly in smaller or remote communities if health professionals were absent for extended periods and/or if replacement personnel were not appropriately qualified and sufficiently experienced.

4. Employment Security.
   a) Health professionals might not wish to return to their original employment situation after an extended leave.

b) Positions may have changed or have been closed during the period of the leave so the original position is no longer available when the health professional returns from leave.

5. Educational Considerations.
   a) Implementing a system of paid educational leave might create a sudden, dramatic increase in the demand for continuing education programs. Continuing education providers would have difficulty responding to this demand with appropriate programs of high quality if this were expected to be done with existing personnel, facilities and financial resources.
   b) A system of paid educational leave paid out of public funds would obligate providers to ensure the availability of programs of consistent high quality. No mechanism is in place to ensure this at the present time. A review mechanism similar to those used for the accreditation of undergraduate and postgraduate training programs might be appropriate.

6. Disruption to Families.
   A system of leave could cause disruption and even hardship for families particularly where absences are prolonged. Special consideration may have to be given and additional resources applied in such situations.

RELATED CONSIDERATIONS

1. Professional Accountability.
   a) Individual health professionals should bear a portion of the cost of continuing professional education because professional development is part of their responsibility as a health professional and because greater emphasis may be placed in deriving benefit from the activity if the individual pays part of the cost.
   b) A formula should be used to determine what portion should be paid by the individual. A 50:50 split was suggested.
   c) Part of the responsibility of the individual to bear some of the cost is satisfied if tax dollars are used to fund the leaves because the recipients are tax payers.
   d) If paid educational leave becomes a right, health professionals should expect to be accountable for the results of the educational process through examinations or assessment of competence.

2. Educational Considerations.
   a) Continuing education providers would have to receive increased resources in terms of funding, personnel and facilities to respond effectively to a system of universal paid leave.
   b) The nature of continuing education would have to be scrutinized and should be expected to change. In the past, continuing education has tended to be short-term and specific, relating to particular tasks and functions. With a system of paid leave, it would have to embrace much broader concepts, allowing for systematic and sequential planning for career development, role change, etc.
   c) The role of continuing education in the educational system would have to be re-defined and modified. Almost without exception, continuing education programs are ancillary functions in educational institutions

whose primary role is not to provide continuing education. If continuing education is to remain within existing institutions, status and resources commensurate with other major programs would have be accorded.

3. Universality.
   a) If paid leave is instituted it should be uniformly available to health professionals in all disciplines and at all levels, including those not referred to in this submission.
   b) The unique needs of special categories of individuals would have to be considered.
      - the unemployed.
      - single parents or widows/widowers suddenly forced to return to the marketplace.
      - the disabled or partially disabled.

4. Administration.
   a) Leaves should be structured so continuing education is concurrent with rather than separate from professional practice. This could be accomplished by part-time or short-duration leaves at regular intervals allowing for the integration of new learning into clinical practice. This would also make continued learning an ongoing expectation.
   b) A number of practical questions require answers.
      - How would duration, frequency, purpose of leaves be established and monitored?
      - How would the system operate for self employed professionals?
      - Would the system apply to professionals desiring career advancement; e.g. Licensed Practical Nurses desiring to become R.N.'s?
   c) The system must have flexibility to cope with needs for programs of varying length and with varying needs of individual professionals.
   d) A "banking" system would be useful to enable people to take longer leaves.
   e) Flexibility would be helpful so vacations and other benefits could be combined.

5. Funding Mechanisms.
   a) Physicians
      The B.C. Medical Education Fund was recommended as a model for professionals employed on a fee-for-service basis.
   b) Pharmacists
      Many prescriptions are now handled under the provincial government's Pharmacare program. A few cents of the cost of each prescription could be set aside in a fund for continuing education purposes. A similar system is already in place, in which a few cents per prescription provide funding for furthering the activities of the B.C. Pharmacists Society.
   c) Income Tax Concessions
      Changes could be made in income tax laws to relieve some of the costs of participating in continuing education. Costs not usually allowed should be considered; e.g. housekeepers or babysitters.

6. Monitoring Systems.
It is important the system be carefully monitored and responsibility for monitoring be shared and clearly defined.
   a) Educational institutions should be responsible for monitoring the quality of programs and the educational outcomes.
   b) Professional associations should be responsible for monitoring the quality of health care and performance outcomes.

7. Educational Leave "In Situ".
In-service training provided by hospitals, particularly on-the-ward training and supervision of new nursing graduates is a form of "in-situ" educational leave.

8. An Important Alternative.
Perhaps the funds should not be spent on paid educational leave but rather on increasing the supply of health professionals to provide the care. Professionals are too busy to provide the care they have been trained for. A comprehensive approach to treatment seems to have been replaced by a functional (fragmented) approach.

APPENDIX A

LIST OF THOSE INTERVIEWED

1. AUDIOLOGY AND SPEECH SCIENCES

1) Ms. L. Duncan
Co-Director (Speech Pathology)
Division of Continuing Education in Audiology and Speech Sciences
Room 105 - 2194 Health Sciences Mall
University of British Columbia
Vancouver, B.C. V6T 1W5

2) Ms. N. Lamb
Co-Director (Audiology)
Division of Continuing Education in Audiology and Speech Sciences
Room 105 - 2194 Health Sciences Mall
University of British Columbia
Vancouver, B.C. V6T 1W5

3) Ms. C. Macmillan
President
B.C. Speech and Hearing Association
c/o Family Services of Greater Vancouver
1616 W. 7th
Vancouver, B.C. V6J 2S5

2. DENTISTRY

1) Dr. M.F. Williamson
Assistant Dean and Director
Division of Continuing Dental Education
Room 105-2194 Health Sciences Mall
University of British Columbia
Vancouver, B.C. V6T 1W5

2) Ms. J. M. Wong
Assistant Director
Division of Continuing Dental Education
Room 105 - 2194 Health Sciences Mall
University of British Columbia
Vancouver, B.C. V6T 1W5

3) Dr. G. Thordarson
Registrar
College of Dental Surgeons of B.C.
Vancouver, B.C. V6H 3N4

3. HUMAN NUTRITION AND DIETETICS

1) Dr. N. Schwartz
Director
Division of Continuing Education in Nutrition and Dietetics
Room 105 - 2194 Health Sciences Mall
University of British Columbia
Vancouver, B.C. V6T 1W5

2) Ms. P.D. Glencross
President
British Columbia Dietitians and Nutritionists Association
200 - 8582 Fraser Street
Vancouver, B.C. V5X 3Y3

4. MEDICINE

1) Dr. D. S. Lirenman
Associate Dean and Director
Division of Continuing Medical Education
Room 105 - 2194 Health Sciences Mall
University of British Columbia
Vancouver, B.C. V6T 1W5

2) Dr. J. Hutchinson
Registrar
College of Physicians and Surgeons of B.C.
1807 West 10th Avenue
Vancouver, B.C. V6J 2A9

3) Dr. H. Stansfield
Director of Professional Relations
B.C. Medical Association
1807 West 10th Avenue
Vancouver, B.C. V6J 2A9

5. NURSING

1) Ms. S. L. Brandt
Director
Division of Continuing Nursing Education
Room 105 - 2194 Health Sciences Mall
University of British Columbia
Vancouver, B.C. V6T 1W5

2) Mrs. P. Cutshall
Executive Director
Registered Nurses Association of B.C.
2855 Arbutus
Vancouver, B.C. V6J 3Y8

3) Ms. D. Robinson
Education Consultant
Registered Nurses Association of B.C.
2855 Arbutus
Vancouver, B.C. V6J 3Y8

6. PHARMACY

1) Dr. D. W. Fielding
Director
Division of Continuing Pharmacy Education
Room 105 - 2194 Health Sciences Mall
University of British Columbia
Vancouver, B.C. V6T 1W5

2) Mr. F. Archer
President
B.C. Pharmacists Society
604 - 1200 West 73rd Avenue
Vancouver, B.C. V6P 6G5

3) Mr. N. Thomas
Registrar
College of Pharmacists of B.C.
240 - 1575 West Georgia Street
Vancouver, B.C. V6G 2V3

7. REHABILITATION MEDICINE

1) Ms. L. Harvey
Director
Continuing Education in Rehabilitation Medicine
Room 105 - 2194 Health Sciences Mall
University of British Columbia
Vancouver, B.C. V6T 1W5

2) Ms. D. Hallgren
President
B.C. Society of Occupational Therapists
Children's Hospital
4480 Oak Street
Vancouver, B.C. V6H 3V4

3) Ms. M. Cross
President
The Physiotherapy Association of B.C.
Children's Hospital
4480 Oak Street
Vancouver, B.C. V6H 3V4

8. SIGNIFICANT OTHERS

1) Dr. B.E. Riedel
Co-ordinator, Health Sciences
4th Floor, 2194 Health Sciences Mall
University of British Columbia
Vancouver, B.C. V6T 1W5

2) Dr. H.O. Murphy
Former Chairman
Division of Continuing Education in the Health Sciences
University of British Columbia
Vancouver, B.C. V6T 1W5

3) Mrs. M.S. Neylan
Former Chairman
Division of Continuing Education in the Health Sciences
University of British Columbia
Vancouver, B.C. V6T 1W5

4) Ms. P. Wolczuk
Dept. Head, Health Continuing Education
British Columbia Institute of Technology
3700 Willingdon Avenue
Burnaby, B.C. V5G 3H2

5) Mrs. F. Collins
Program Co-ordinator, Health Sciences Program
University Extension
P.O. Box 1700
University of Victoria
Victoria, B.C. V8W 2Y2

APPENDIX B

INTERVIEW SCHEDULE

SKILLS DEVELOPMENT LEAVE TASK FORCE
PAID EDUCATIONAL LEAVE FOR HEALTH PROFESSIONALS

INTERVIEW SCHEDULE #1

DIRECTORS OF CONTINUING EDUCATION

1. Roles of Continuing Education:

   1) In what forms is Continuing Education currently being provided to members of your profession?

   2) What are the roles of Continuing Education in your profession?
   eg. maintaining basic competence
   acquiring new knowledge and skills
   facilitating role changes
   professional advancement.

   3) Is Continuing Education as it currently exists adequately fulfilling those roles? If not, why?

   4) Is Continuing Education mandatory (required) in any way for members of your profession?
   If so:
   a. What is the requirement?
   b. What body has established the requirement?
   c. For what purpose?
   d. How is the requirement monitored?
   " " " " enforced?

2. Relationship of Continuing Education to Paid Educational Leave:

   1) Does any form of paid educational leave exist for members of your profession at the present time?

   2) If paid educational leave does not now exist for members of your profession, do you feel that it should be instituted? Why? or Why not?

   3) If paid educational leave does exist for members of your profession, do you feel the terms and conditions should be modified in any way? If yes, how?

   4) If paid educational leave were provided for all members of your profession:
   a. What advantages can you see?
   b. What disadvantages (or problems) can you see?

3. General Considerations:

Do you have any observations, comments, suggestions, or recommendations about paid educational leave for members of the health professions?

SKILLS DEVELOPMENT LEAVE TASK FORCE
PAID EDUCATIONAL LEAVE FOR HEALTH PROFESSIONALS

INTERVIEW SCHEDULE #2

ASSOCIATION REPRESENTATIVES

1. Roles of Continuing Education:

   1) What are the roles of Continuing Education in your profession?
   eg. maintaining basic competence
   acquiring new knowledge and skills
   facilitating role changes
   professional advancement

   2) Is Continuing Education as it currently exists adequately fulfilling those roles? If not, why?

2. Relationship of Continuing Education to Paid Educational Leave:

   1) Does any form of paid educational leave exist for members of your profession at the present time? If yes:
   a. Who pays the cost of the leave?
   b. What are the general terms: duration of leaves, frequency, etc.
   c. What are the financial conditions as they relate to salary support, tuition fees, travel costs, etc.

   2) If paid educational leave does not now exist for members of your profession, do you feel that it should be instituted? Why? or Why not?

   3) If paid educational leave does exist for members of your profession, do you feel the terms and conditions should be modified in any way? If yes, how?

   4) If paid educational leave were provided for all members of your profession:
   a. What advantages can you see?
   b. What disadvantages (or problems) can you see?

3. General Considerations:

   1) a. What types of practice do members of your profession engage in?
   b. What proportion of your membership (approximately) engages in each type of practice?

   2) Do you have any observations, comments, suggestions or recommendations about paid educational leave for members of the health professions?

SKILLS DEVELOPMENT LEAVE TASK FORCE

PAID EDUCATIONAL LEAVE FOR HEALTH PROFESSIONALS

INTERVIEW SCHEDULE #3

SIGNIFICANT OTHERS

1. Roles of Continuing Education:

   1) What are the roles of Continuing Education in the health professions?
   eg. maintaining basic competence
   acquiring new knowledge and skills
   facilitating role changes
   professional advancement

   2) Is Continuing Education as it currently exists adequately fulfilling those roles?

2. Relationship of Continuing Education to Paid Educational Leave:

   1) If paid leave were provided to all members of the health professions for continuing education purposes:
   a. What advantages can you foresee?
   b. What disadvantages (or problems) can you foresee?

   2) Do you have any observations, comments, suggestions, or recommendations about paid education leave for members of the health professions?

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Enquiries and Distribution
Public Affairs
Employment and Immigration Commission
140 Promenades du Portage
Hull, Québec
K1A 0J9
(819) 994-6313